Domestic Violence Prevalence Rates, Effects, and Risk Factors Among Arab Women

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Dedication

First and foremost, I dedicate this dissertation to God for guiding and strengthening me throughout graduate school. All glory be to His name. A special dedication to my family: my father for his constant support and endless sacrifices, my mother for her unconditional love and sleepless nights with me, and my sister for always picking me up and believing in me even at my lowest moments.

This dissertation product is dedicated to every woman who grew up challenging gender roles, societal beliefs, and patriarchal and oppressive systems. To all the women who have once endured any form of domestic violence and tolerated abuse, fearing for their lives, their families' reputations, and their children's futures. To all women's voices who have been silenced and to women who have lost their lives to domestic violence, may this dissertation be a step towards regaining your dignity, healing from your unseen wounds, and seeking justice on the behalf of each of you.

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Abstract

Domestic Violence (DV) is a widespread human rights violation impacting women's lives, costing them not only physical injuries and complications but also significantly impacting their emotional and psychological well-being. Domestic violence has been a more serious concern among Arab women due to its higher prevalence rates resulting from the intersectionality of unique societal, religious, and cultural factors in Arab societies. These factors also constitute risk factors for experiencing DV and barriers to Arab women seeking or accessing culturally sensitive mental health services and legal support. This dissertation aims to explore the cultural traditions, beliefs, and value systems contributing to the prevalence of DV among Arab American women, along with exploring other intersectional identities and vulnerabilities of this target population to inform clinicians in assessing DV and offering culturally responsive interventions to women victims. The product of this dissertation is a psychoeducational manual informed by qualitative research approaches in providing a systematic review that discusses definitions of DV, global statistics of DV, Arab regional prevalence rates of DV, culturally influenced risk factors and resilience factors, and culturally sensitive interventions for tackling the DV issue among the target population. This project was also reviewed and evaluated for the manual's content relevancy, effectiveness, practicality, and cultural appropriateness by clinicians who come from Middle Eastern backgrounds or who have clinical experience with Middle Eastern populations to ensure their familiarity with the cultural norms, societal expectations, belief systems and values, and needs of the Arab American women, supporting the improvement of the manual's sections, particularly those focusing on offering culturally appropriate interventions to meet the unique needs of Arab American women.

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Chapter I

Introduction

Statement of the Problem

This study is a non-empirical study of a booklet that explores the heightened rates of DV, risk factors, and its effects among Arab women. The Eastern Mediterranean region, where the population of the study originates from, was found to have the second-highest DV rates among women, with a rate of 31%, as reported by the World Health Organization (WHO) (WHO, 2021). Domestic violence prevalence rates remain high due to the normalization of women's battering, whether through societal norms, gender expectations, or lenient laws, contributing to the persistent victimization of Arab women.

Purpose of the Dissertation

Domestic violence is an issue in many societies that remains prevalent and widespread. However, DV remains understudied in the Middle Eastern and Arab regions compared to the Western world. This research scarcity amongst Arab and Arab-American women can be explained by different reasons, such as avoidance of stigmatized topics such as DV and fear of spreading and perpetuating stereotypes (Abboud et al., 2022b). The importance of studying DV among Arab women arises from the lack of research on this issue within the Arab women population. The population of Arab women is one with multiple marginalized identities and individual DV risk factors. Therefore, understanding their intersectional identities and the traditions, societal norms, religious beliefs, and other unique circumstances accompanying them is crucial in effectively working with Arab women and offering them more culturally sensitive treatment interventions.

Gendered Violence Targeting Arab Women

Domestic Violence (DV) is one of the most prevalent issues that women still face in our society to this day. Domestic violence remains a major factor in causing physical injuries among women. It is approximated that 30% of women worldwide are subjected to DV and abuse at a certain stage in their lives, and around 25.7% of women's visits to the emergency room are connected to their exposure to incidents of DV (WHO, 2021). Globally, it is approximated that 38% of female homicides are perpetrated by male partners (WHO, 2013). Intimate Partner Violence (IPV), also known as DV, includes not only effects on physical and psychological health but also negative effects on their sexual and reproductive health. Domestic Violence has several forms besides physical abuse and battering, including emotional, sexual, psychological, and economic abuse. Women worldwide have been victims of DV for decades, as they have been seen as physically, emotionally, and intellectually inferior to men in many societies (Elghossain et al., 2019).

Domestic abuse and violence can result in various severe consequences on women's well-being, such as physical injuries, chronic pain, sleep disturbances, migraines, pelvic pain, gastroenteritis, and ulcer formation (Khadra et al., 2014). As reflected in the Centers for Disease Control and Prevention (CDC) statistics obtained through the National Intimate Partner and Sexual Violence Survey (NISVS), it is estimated that $5.8 billion is spent on healthcare and psychological costs that result from IPV annually in the U.S. (CDC, 2014). The NISVS survey also indicated that Black and multiracial women and immigrant women exhibit higher lifetime prevalence rates of physical violence than white-identified women (CDC, 2014). Women who had experienced any form of abuse have indicated elevated levels of fear, anger, and overall psychological distress compared to non-abused women (Haj-Yahia, 1999). The detrimental consequences of DVA go beyond physical harm to also include profound emotional and psychological effects, such as

somatic symptoms, anxiety, PTSD, depression, and even suicidal tendencies (Khadra et al., 2014). Women who experienced severe forms of DVA have also been found to exhibit symptoms of PTSD, frequently manifested as recurring nightmares, intrusive flashbacks of the abusive incidents, attempts to evade recalling the abuse, and heightened arousal states (Khadra et al., 2014).

Domestic violence experiences are tied to the profound feelings of guilt, blame, and humiliation in its victims, hindering them from breaking the pattern of recurring abuse. Furthermore, the social mores of the Arab world that encourage institutionalized oppression of women have made it exceptionally challenging for women to seek supportive services or speak up about the abuse they have endured. In fact, out of the 22 Arab countries, Jordan, Lebanon, Tunisia, Morocco, Bahrain, and Saudi Arabia are the only countries that are acknowledged to have certain established laws and protections in place for women against DV, according to The Globalist (2019). Also, religious doctrines of the major religions and religious groups in the Arab World would often contain permission for physical punishment against women by their husbands or legal guardians in the cases of disobeying or being rebellious against them. Certain religious doctrines have even extended to afford men, whether husbands or legal guardians, protection from any consequences for their actions, particularly if the abuse fell within a specified severity range of physical punishment against women. These doctrines persist in various conservative regions across the Arab world (Abu-Ras, 2007). These doctrines have resulted in the silencing of many victims of DV in the Arab world, and as some Arab regions are more conservative than others, some women lose their lives due to the violence suffered in silence, in fear of society, and even their close ones. In a systematic review conducted by Elghossain et al. (2019), it was revealed that merely half of the 21 Arab countries have conducted eligible surveys on the issue

of IPV prevalence. However, the fragmented evidence and research suggest that IPV in the Arab region constitutes a major concern to the health of the public and fundamental human rights.

Israa Ghrayeb, a young Palestinian woman who tragically lost her life due to DV in 2019 at the hands of her father and brother, was one of many Arab women who were abused due to suspicions about keeping the honor of the family. Israa Gharyeb was beaten up and choked to death in September 2019 because she posted pictures of herself with her fiancé on social media. Her family claimed her murder to be an honor killing as those situations are dealt with less strictly in Arab countries. The Ghrayeb family even asked the hospital where Israa was beaten to death to do a "virginity check" to justify their murder of her. Israa was one of numerous Arab women who lost their lives due to DV, the honor killing laws, and religious allowances perpetuating these brutal behaviors until this day. Furthermore, because of Israa, battered Arab women, and the many other women fighting the unfair societal mores and religious doctrines, DV has started to be a topic that is discussed publicly with no shame in more Arab countries today (Al Arabiya English, 2020).

The Arab world, which consists of the 22 countries constituting the Arab League, hosts a population of 436 million people as of 2020 (The World Bank, 2022). As reported by the World Bank Data from 2018, Arab women comprise approximately half of that population, with about 216 million women (48.2%). Although DVA is not limited by gender, to this day, most DVA acts continue to be experienced by women. Around one-third of women globally report involvement in relationships where they faced violence perpetrated by their romantic partner or family member (Heywood, 2019). Another study comparing the DVA gap between Arab and Jewish women in Israeli shelters revealed that the rates of police complaints filed against Arab perpetrators were lower compared to Jewish perpetrators (Ben-Porat, 2017). This finding demonstrates the cultural

gap between Arab and Jewish women and how it affects whether women take any legal action against those who abuse them. Arab women who reported experiencing DVA were observed to be of a younger age, possessed lower education levels, and had lower chances of joining the workforce relative to Jewish women (Ben-Porat, 2017). Arab women in most of these countries have been restricted by religion, culture, and traditions from living independently and freely. Socio-economic status (SES) in the Arab region does not appear to significantly impact Arab women's risk of encountering DV, as women's rights remain largely unattained in that region of the world. However, a higher SES level makes it easier for women to escape DVA due to having more financial resources (Haj-Yahia, 1998). Arab women have also been fighting for equal rights compared to men in this part of the world for decades in some countries like Saudi Arabia, where women gained their right to drive and travel abroad without permission from a male relative only in 2019 and 2020, respectively. In Egypt, women are still fighting for their right to guardianship of their children during a divorce because the children are awarded to men since women cannot get any paperwork done for their children without their father's signature. For decades, Arab women have been fighting for gender parity in education, politics, or the workforce. Although women have been conditioned to remain silent about any form of abuse generally, Arab women have been silenced for so long due to the additional layers of cultural traditions and the shame associated with speaking up about the abuse perpetrated by family members. Acceptance of DVA acts and the justifications given to partners or parents who commit them against women are results of society's belief in male authority and control over female family members in the Arab region (Haj-Yahia, 1998).

While Arab women have been fighting for social, political, and educational equality in the Arab region, the majority of Arab countries to this day have not achieved gender parity in

something as fundamental as education. Girls in Morocco and Yemen experience unequal access to educational privileges compared to boys (Elghossain, 2019). Giving women no gender parity plays a huge role, especially in making younger girls believe that they are not as capable as men, leading to the prevalence of DVA against Arab women. Gender imparity, along with the societal mores and some oppressive religious doctrines, creates scared girls who grow up to be silenced women who cannot take the shame associated with speaking up about DVA.

There are many forms that DVA can take other than physical abuse, so women survivors of DVA could have experienced it in the forms of psychological, emotional, sexual, or financial abuse. In a study conducted among 60 Muslims and Christian-Armenians residing in Lebanon, it was found that women from low-income backgrounds attributed causes of DVA to unfulfilled marital role expectations such as cooking and cleaning duties, conflict with in-laws, and substance use issues on the part of the male partner (Khadra et al., 2014). So, although some Arab women justify their partners' DVA towards them due to how taboo the subject still is in society, most women do not justify it but recognize some of its reasons.

These women, like many DVA survivor women around the world, are gradually recognizing the seriousness of the DV issue, and they view and identify themselves as victims, survivors, and 'thrivers' (Heywood, 2019). Furthermore, many women preferred the term 'thrivers' because of the positive connotation it carries. In contrast, the term 'victim' was stigmatized within society, as it made them feel less powerful and less in control of their lives (Heywood, 2019). Therefore, this research aims to study the risk factors leading to the higher incidence rates of DV and how these factors influence women's lives in various areas to aid in the process of working with this unique population on issues of DV. This booklet will be a resource for mental health practitioners, including case managers, social workers, clinical psychologists,

marriage and family therapists, and other professionals in the mental health field, to utilize in assessing and working with DV victims and survivors of Arab women.

Chapter II

Literature Review

In this chapter, the human rights issue of DVA is brought to light by acknowledging how the immigrant Arab community remains under-researched, making it crucial to review previous research on DV among Arab women. This literature review aims to provide a glimpse of the possible risk factors, cultural traditions, societal beliefs, and other unique circumstances in the lives of Arab women that impact their lived experiences of DVA. This literature review begins with a definition of DV provided along with world statistics and laws about DV compared with the prevalence rates and laws of DV for the population of focus, Arab women. The demographics of Arab women, DV statistics, and types of DV are also described to evince the cultural attitudes and beliefs of the Arab regions influencing the elevated rates of DV prevalence and statistics among Arab women compared to world DV statistics. Then, the various risk factors are reviewed to list how they contribute to the higher rates of DV and underreporting of DV incidents among Arab women, including factors such as cultural traditions, religious beliefs, and societal norms. This literature review on DV among Arab women focuses on the protective factors and the socially acceptable resources that need to be considered and recognized to utilize in supporting Arab women and reducing the prevalence rates of their DV experiences. Herein, the cultural influences that impact DV and its prevalence are identified, such as religious factors, societal norms, age of marriage, SES, and lack of cultural support. Then, the overarching Middle Eastern culture and Arab cultural norms are discussed to highlight the overlooked factors in the Arab cultural norms, customs, and traditions leading to higher DV rates among Arab women. These cultural traditions and practices necessitated discussing Female Genital Mutilation (FGM) and honor crimes as current extreme forms of DV against Arab women. Finally, the most utilized

interventions for DV are reviewed, and the interventions and psychoeducation tools that would be most culturally appropriate to use in treatment with Arab women victims and survivors of DV are presented, followed by a conclusion section with the rationale for my project.

Prevalence and Definition of Domestic Violence (DV)

Dokkedahl et al. (2019) describe DV as a range of behaviors within intimate partnerships intended to inflict physical, psychological, or sexual harm (Dokkedahl et al., 2019). The WHO describes DV as a form of abuse rooted in its inequality against women, comprising physical, emotional, and sexual abuse and other dominating acts perpetrated by a partner or family member (WHO, 2012, p. 1). Women trafficking, female genital mutilation practices, and honor killings are regarded as severe manifestations of gender-based abuse towards women (Garcia-Moreno et al., 2013). The expression "battered women" refers to the action of battering experienced by women as a severe form of DV that is characterized by various forms of physical abuse, threats, and restricting and dominating behaviors done by the abuser toward their victim (WHO, 2012).

Domestic violence (DV) or IPV is a worldwide issue posing a concern to both the health and fundamental rights of women, for its dire and long-lasting implications on women's physical health and emotional resilience. Although physical and psychological types of DV are estimated to be the most prevalent forms, DV includes a broader array of behaviors and forms intended to cause harm to the victims. Existing research also indicates the frequent coexistence of different forms of DV or IPV; thus, physical IPV is often accompanied by both emotional and sexual IPV (WHO, 2012). In a multi-nation study led by WHO (2005), a percentage of women ranging between 23 and 56% disclosed enduring physical and sexual forms of IPV. As outlined in the WHO (2021) fact sheet, the incidence of IPV across women's lifetimes is estimated at 20% in the Western Pacific and 22% in Europe and higher-income nations, 25% in parts of the Americas, and

escalates further to 31% in the WHO Eastern Mediterranean regions and 33% in both the African areas and South-East Asia regions recognized by the WHO. As the results of the WHO (2021) fact sheet reveal, Arab women in the Mediterranean region experience some of the most elevated prevalence rates of IPV, ranking second highest in prevalence worldwide. These findings reveal the severity of DV as a pressing issue endangering the health and rights of the study's focus group of Arab women. These findings also call for more comprehensive research and intervention development studies to aid in the early intervention and prevention of DV among Arab women.

DV Statistics and Laws Worldwide

Domestic violence studies across different cultures have demonstrated that physical violence and assault against women occur across all social classes, belief systems, and economic tiers While women may commit DV towards their male partners, this study focuses on DV victims and survivors of women, as research reveals men have a higher tendency to perpetrate DV against female partners (Heise et al., 1999). It is estimated that one in three (30%) women globally have been victims of sexual or physical abuse perpetuated by a partner or male relative throughout their lives, according to the analysis of DV prevalence rates across 161 countries (WHO, 2021). It is estimated that 8% of global female homicides are perpetrated by their spouse or romantic partner, while 42% of women who endured IPV report sustaining injuries resulting from such violence (WHO, 2021). As reported by the National Statistics Domestic Violence Fact Sheet (NCADV) (2022), one in every three American women has endured a form of DV by a partner, while one in every seven American women has experienced bodily harm inflicted by a romantic partner.

Rape is a type of sexual IPV that is unfortunately still prevalent worldwide. It is estimated that one out of every 10 women living in the U.S. reports being a victim of rape by a

romantic partner (NCADV, 2022). Nationwide, DV hotlines receive approximately 20,000 phone calls on a typical day reporting some form of DV (NCADV, 2022). As of May 2016, a member of the World Health Assembly disclosed adopting an inclusive initiative to enhance the capacity of health systems in detecting and addressing violence and abuse, particularly violence affecting women and children (WHO, 2021).

Federal laws attempt to prevent and reduce American women's exposure to domestic abuse by considering all DV incidents felonies (The United States Department of Justice, 2021). The Violence Against Women Act (VAWA) was enacted in 1994 by Congress as a step to acknowledge DV as a national crime (The United States Department of Justice, 2021). Additions to the VAWA and more federal laws were passed in 1996 to help ensure women's safety in DV cases, including the changes to the Gun Control Act to introduce it as a federal crime to access firearms as convicted DV perpetrators or under restraining orders of a qualifying DV offense (The United States Department of Justice, 2021). National assistance is also available for victims of DVA through the Domestic Violence Hotline, the National Coalition Against Domestic Violence, and local assistance, such as local DV shelters and police stations.

As part of global efforts to combat DV directed toward women, the United Nations (UN) Women, the WHO, and additional international agencies have crafted RESPECT Women, a comprehensive tool developed to guide policymakers in the process of preventing DV against women. The RESPECT framework identifies seven strategic pillars to prevent DV against women: promoting healthy relationship dynamics, increasing women's agency and decision-making power, ensuring the availability of essential services, addressing economic hardship, creating secure and supportive settings, preventing early abuse in childhood and adolescence, and challenging harmful social attitudes and cultural norms. (WHO, 2021). The seven strategies

of RESPECT consist of a wide array of interventions and resourceful settings designed to attend to the unique needs of women with a history of DVA in any form (WHO, 2021).

Most of the Arab countries do not have specified laws that denounce DV and protect women against it, but attempts are rising to offer the supportive tools to support Arab women affected by DV ("Violence Against Women in MENA", 2021). In Tunisia, social services have an established complaint system to receive complaints from DV victims, while a shelter for women facing the threat of honor crimes was established in Jordan ("Violence Against Women in MENA", 2021). The first shelter for women, The House of Eve, was founded in Egypt less than a decade ago in response to widespread DV became a pervasive phenomenon in Egyptian society. It was not only the first shelter for women in Egypt but in the entire Arab region (The Globalist, 2019). In Morocco, counseling centers have been set up to allow women to talk about their marital problems and receive any help needed if DV occurs, according to The Globalist (2019). Although initiatives were pursued to advance women's rights in the Arab region, the achievements have been undermined by the continuous violence and discrimination that Arab women face in different settings and matters such as inheritance, educational opportunities, child custody, and job opportunities.

The worldwide DV statistics of one out of every three women experiencing DV at least once in their lifetime confirm the seriousness of the DV issue; however, the higher rates of DV among Arab women reveal the cruciality of research on this population. It is also crucial to research this population's traditions and customs, social norms regarding DV, and different DV laws, as well as study the culturally appropriate and available resources to utilize in therapy with Arab women who are DV victims and survivors. To better understand this unique population and their lived DV experiences, the next section discusses Arab women's demographics, as Arab women

come from various ethnicities, cultural backgrounds, and religious backgrounds, which would result in varying DV experiences and different help-seeking behaviors depending on what the DV victims' environment deems as acceptable. The next section also includes in-depth definitions of the different DV types and the Arab region's DV statistics. The Arab region's DV statistics are discussed in light of the societal justifications specific to that region of the world, which contribute to higher DV statistics among Arab women compared to Western women.

Arab Women Demographics, and DV Statistics and Types

The Arab world today, as we know it, consists of 22 countries with a population of 464 million people as of 2020. Based on the World Bank Data from 2020, Arab women comprise almost half of that population, with about 223 million women (48.2%). About 30% of women worldwide report being in a romantic relationship marked by violence perpetrated by their partner or family member (Heywood, 2019). Domestic violence has been a normalized phenomenon that, when widespread, resulted in invisible crimes in many societies (Niaz et al., 2017). In the Middle Eastern region, the proportion of women reporting encounters of a type of DV is comparatively higher than the world average at 37%, along with indicators that the on-ground percentage might be higher (El-Nimr et al., 2021). Women in the 22 Arab countries have been restricted by religion, culture, and traditions from achieving equal rights compared to men. For decades, Arab women have been fighting for gender parity, whether in education, politics, or the workforce. Similar to many women around the world, Arab women have been taught not to speak up about DV due to the conservative cultural traditions and the shame associated with the abuse. The tolerance of DV and the rationalizations given to partners or parents who commit these acts against women are mainly due to society's belief in male authority over female family members (Haj-Yahia, 1998). Since male dominance over women in the Arab world is a pervasive belief, the fight against this

traditional belief is crucial to witness and encounter real change and action toward DVA laws and its victims of Arab women.

In some Arab countries like Egypt, Palestine, and Tunisia, surveys have found that one in every three women has undergone some form of physical intimate partner violence (Douki et al., 2003). The Egyptian Demographic and Health Survey for the year 1996 had a sample of 14,779 and found that one out of every three married Egyptian women was physically abused at least once during their marriage, while one-third of these women were victims of physical violence during their pregnancies (El-Zanaty et al., 1996). For 2005, the Demographic and Health Survey of Egypt found IPV prevalence as high as 47% among women, with previous or current husbands being the most commonly reported perpetrators (El-Zanaty & Way, 2006). The survey also found that nearly half of the women aged 15-49 who have been married reported encountering physical battering, including getting hit or slapped, at some point after age fifteen (El-Zanaty & Way, 2006). Another important finding in the Demographic and Health Survey of Egypt was the strong correlation between women's marital status and the likelihood of ever experiencing DV in their lifetime, with 75% of the reported divorced or separated women experiencing at least one DV incident compared to 43% of currently widowed women and 45% of currently married women (El-Zanaty & Way, 2006). In another study by Belhaj et al. (1998), a survey conducted with 500 Tunisian women showed that 33.8% of women reported getting physically abused by their husbands or another male family member at least once in their lifetime. These surveys from different Arab countries indicate how many Arab women are at risk of DV regardless of their region of residence, age, and marital status (Haj Yahia, 2001). In Medina, Saudi Arabia, 689 married and previously married women were interviewed in primary health care centers, answering a questionnaire containing items gathered from three different

measures (Modified Conflict Tactic Scale, Kansas Marital Scale, and the Lie Scale of the Minnesota Multiphase Personality Inventory). The questionnaire aimed to assess the frequency and forms of DVA experienced by Saudi women. The results found that out of the 689 women, 25.7% experienced physical abuse, while 32.8% indicated experiencing psychological abuse with no battering incidents (Al-Tashkandi, 2009). Of the percentage that reported physical abuse, 36.7% of women reported suffering from minor DV incidents, while 63.3% reported experiencing severe incidents of physical abuse. The reported rate of abuse by Arab women throughout their lifetime was 57.7%, a significantly higher rate compared to DV rates among women worldwide (Al-Tashkandi, 2009). The same study found that only 36.7% of 109 abused women had disclosed their physical abuse experiences with their primary care physician, indicating the shame surrounding speaking up about DV or seeking professional help. This study demonstrates how DV is still not treated as a severe, prevalent problem and a crime against Arab women in that region of the world. The lower rates of DV reporting among Arab women can be indicative of various factors, including a perceived lack of safety in disclosing DV to professionals, adherence to cultural traditions regarding the significance of family preservation, and the wish to protect the family's reputation and avoid any shame by refraining from speaking up about DV or asking for divorce.

The normalizing of DV and the lenient laws decriminalizing DV perpetrators, particularly in the Arab world, are direct results of the society's belief in male supremacy over female family members (Haj-Yahia, 1998). Domestic violence concerns the harmful acts and abuse inflicted by a romantic partner or a relative within the family against their victim. As defined by the National Coalition Against Domestic Violence's Vision (NCADV), forms of DV include any abusive behavior that is exhibited to assert power or dominate the other in many ways that extend beyond

physical abuse to include psychological, sexual, and financial exploitation and abuse, along with coercion and stalking (NCADV, 2022). Although intact evidence and a database of IPV against Arab women do not exist, previous and current studies have found substantial levels of IPV, including physical violence, emotional manipulation, and sexual abuse against Arab women in many settings (Elghossian, 2019). Domestic violence definitions remain the same in the Arab world, and their forms are similar. The main difference is how some DV forms, such as financial abuse, are more prevalent in the Arab region than in the rest of the world. However, the traditions and cultural norms dictate Arab women's behaviors to a great extent, as women are seen as the ones that bring shame to their families in many ways, including challenging men's authority, dressing immodestly, separating from their husbands, asking for a divorce, and any other activity that might be perceived as belittling the family's honor, as women are seen as the honor of the family in that part of the world (Abu-Ras, 2007).

Domestic violence can manifest as a single incident or repeated acts of abuse, presenting in various ways, such as physical, psychological, emotional, or financial harm, as well as sexual abuse and controlling behaviors. The violence experienced by women only is classified as gender-based violence, and just like DV, García-Moreno et al. (2013) discussed the varying patterns of gendered violence, such as IPV, sexual abuse by non-partners, and harmful practices like female genital mutilation (García-Moreno et al., 2013). The pervasiveness of the DVA types endured by women worldwide varies, and it is common for women to encounter more than one form of DVA over the course of their lives. However, Arab-American women predominantly reported psychological or emotional IPV as the most widespread pattern of IPV (Khan et al., 2021). Emotional IPV was also found to be a precursor to experiencing future physical abuse (Khan et al., 2021). Although physical IPV was openly discussed in the same study by Khan et

al. (2021), sexual IPV was perceived as sensitive and too private to discuss openly. Unfortunately, many of these gender-based forms of violence are still practiced today despite their barbaric nature, such as genital mutilation, which is not banned in most Arab countries except for Iraq and Oman, according to EqualityNow.org. Sexual violence or rape constitutes a form of IPV that not only occurs at higher rates in Arab countries but is augmented by lenient laws across the Arab region to the extent that they can avoid prosecution by marrying their victims. According to UN Women, Morocco is the only Arab country that has repealed these laws after a rape victim decided to end her life due to being forced to marry her rapist.

The higher rates of DV incidents among Arab women can be due to different factors as discussed in this section, varying from cultural, societal, familial, and religious; or even the individual factors of the woman being exposed to this type of abuse. The underreporting of DV incidents was also tied to these factors, which directly impact the safety of the victims and survivors of women who attempt to report their DV experiences despite the stigma and shame associated with speaking up against their perpetrators of family members or partners. The same factors leading to the underreporting of DV incidents were also tied to the normalizing of DV among Arab women and the passing of lenient laws for DV perpetrators in that region of the world. This section also discusses the different forms of DV and the prevalence rates of DV types among Arab women, and it emphasizes how financial abuse prevalence rates in that region remain higher than worldwide prevalence rates due to the traditions and cultural norms that restrict women's behaviors, including seeking similar educational and occupational opportunities as men. Despite financial abuse being a more prevalent form of abuse among Arab women compared to women in the Western world, emotional abuse has been identified as the most common manifestation of DV among Arab women, which is consistent with the worldwide

prevalence rates. This section paves the road to discuss the different levels of DV risk factors and the challenging process of identifying them due to the social barriers faced by Arab women who experience DV or IPV. The impact of the discussed risk factors on the reactions and behaviors of abused women towards DV is still being explored, and it explains why women may choose to refrain from seeking professional help or leaving their abusers.

Risk Factors Perpetuating DV Among Arab Women

Domestic violence is considered an infringement of the fundamental rights of women, supported by cultural taboos and some conservative religious beliefs (Wali et al., 2020). Domestic violence has various dire effects on the physical, emotional, sexual, and reproductive health while also disrupting the overall quality of victims' lives and their families (Mojahed et al., 2020). Unfortunately, DV and abuse are still not perceived as significant issues to be addressed despite their high prevalence rates and increasing frequency in most Arab countries (Douki et al., 2003). Arab women continue to encounter obstacles in receiving equal access to education, social opportunities, economic opportunities, and political representation in most Arab countries (Elghossain et al., 2019). Identifying the risk factors for DV and abuse presents challenges due to the several social barriers and conflicts faced by DV victims of women, hindering their ability to seek support or break away from their abusers (Fugate et al., 2005). The social barriers vary between shame surrounding the issue of DV and the other barriers that come with speaking about it, such as criticism for staying or leaving, fear for one's life, and mistrust of the help source (Vranda et al. 2018). Different types of DV can be found and are prevalent in the Arab region, and Arab women often choose not to speak up or seek support, as found in the study by Morse et al. (2012), as a direct result of the societal stigmatization and shame often associated with DV incidents. The research by Mojahed et al. (2020) classified the various DV

risk factors into four categories following the ecological model. The four risk factor levels included the individual, family, community, and societal levels. The individual level included the risk factors associated with the DV victim or their perpetrator, while the family level included factors connected to marital issues and conflicts within the victim's family (Mojahed, 2020). For both community and societal levels, factors related to any disputes caused by extended family members, the nature of the marriage, and the cultural context, affected by both the political and religious background of the family members, are considered to explore the risk factors leading to the prevalence of DV in the Arab countries (Mojahed, 2020). Researchers also identified the husband's SES as a risk factor for DV, particularly among low-income men, resulting in the increased likelihood of DV against their wives (Mohajed, 2020). In a study by Khan et al. (2021), which consisted of 15 participants, twelve participants (80%) reported viewing IPV as widely accepted and normalized in the Arab American community, while 4 participants reported that Arab-American women's acceptance of IPV is an attempt to avoid larger conflict and shame associated with speaking up about it (Khan et al., 2021). A participant in the same study reported that married IPV victims and survivors who manage to leave their abusive partners face negative reactions from their partners and their own families (Khan et al., 2021). These findings incorporate the stress theory suggesting that low income induces stress, resulting in husbands committing DV against their wives (Smith, 1990). Other scholars argued that the husband's or the household's overall economic standing does not solely indicate the risk of women experiencing DV. However, instead, the woman's financial independence is a more accurate indicator of the likelihood of experiencing DV (Anderson, 2005).

In a similar study conducted by Morse et al. (2012) to identify factors and determinants associated with IPV among a group of 70 married Jordanian women, healthcare providers

identified five themes to address gender based DV among participants. Three of the addressed themes included and entailed the perceived causes of gender based IPV as perceived by the participants, the Arab gender role expectations being unmet, and the social norms regarding the married couple and their extended family roles (Morse et al., 2012). The same study has also found that gender-based family violence has been a theme among women who experience IPV. The family violence was also shown to lead to detrimental health problems in victimized women, yet stigma and shame associated with the abuse remained prevalent, preventing battered women from seeking help, according to Morse et al. (2012). The prevailing lack of concern for the abuse of women by their family members or spouses can be attributed to the normalizing of punishing women for any disagreements or even perceiving such behaviors as private affairs that are never to be shared or dealt with by any third parties. Selective and misinterpreted excerpts from the Quran are frequently employed to rationalize DV by portraying it as acceptable conduct commanded by God (Douki et al., 2003). Numerous studies have suggested that unemployment contributes to women's increased risk for IPV (Faramarzi et al., 2005), and similar associations have been found in studies focusing on Arab and Middle Eastern women (Jeyaseelan et al. (2004). The witnessing of DV by women in their family homes was also found to be strongly associated with the experiencing of physical IPV, as indicated in studies by Jeyaseelan et al. (2004) and Yount and Li (2010). Both witnessing and experiencing DV in childhood have been linked to the approval of and the justification of DV as being acceptable or even "a sign of love" to the wife (Speizer, 2009; Simons et al., 2008). These findings illustrate and support what many studies have found before about the tendency of the cycle of violence and abuse to persist among individuals who witnessed or experienced violence at a young age. Thus, the findings imply that the social learning model is how women learn from those who raise them and that they only hold

a subordinate place in marriage, with their men having control or power over them (Yount & Li, 2010).

Domestic violence remains an infringement of human rights and a concern for health among many Arab women. DV has also been a major and prevalent issue throughout the COVID-19 outbreak among women worldwide. In a study by Abouelenin (2022), results have found women's educational level and being employed to be contributing factors in reducing the incidence of physical IPV among Egyptian women. The study also indicates that the impact of women's employment on IPV is primarily influenced by their partner's employment status. The lowest occurrence of physical IPV was found among employed women with partners who were unemployed (Abouelenin, 2022). While the risk of psychological or emotional IPV was not found to be connected to women's employment and education level, it is to be emphasized that education and employment stand out as substantial deterrents of physical IPV among Arab women. However, no moderation effect was found on physical and psychological IPV, either before or after the rise of the Arab Spring (Abouelenin, 2022). An analysis done by the UN has found connections between violence targeted towards Arab women and societal factors in the Arab world countries, including discriminatory laws, unequal political and economic opportunities, and forced displacement (Elghossian et al., 2019). Studies also suggest that the rigid gender norms embedded in many cultures, including Arab cultures, along with male privileges and masculine notions, play a role in the widespread occurrence of DV against women (Elghossian et al., 2019). Furthermore, the study by Al-Tawil (2012) has found that factors associated with higher rates of DV among Iraqi women included culture, alcohol, the wife's working status, and having children. Women who were born in lower socio-economic status families and gender-stratified societies were also more prone to experience DV (Yount & Li,

2010), while other risk factors for DV were reported among women in six different Saudi cities in a study by Kazzaz et al. (2019) included alcohol or substance use of the husband and the level of education of both the woman and her husband.

Domestic violence is also a prevalent issue within the Arab communities of immigrants and refugees, disproportionately impacting Arab women's lives. It has been observed that DV resulted in the loss of more lives among women of minority groups than women from the Western majority groups (Abu-Ras, 2007). Although in Western countries, immigrant Arab women might have greater access to social organizations and services as well as mental health services compared to their home countries, Arab women still face more difficulty in seeking those services as they remain living in higher-risk situations and under strict cultural conditions, preventing them from seeking and utilizing such services safely (Abu-Ras, 2007). Among Arab immigrant women, DV risk factors remain similar to those among Arab women in the Middle Eastern region with the addition of the new stressors of immigrant status and the family's newly acquired SES (Abu-Ras, 2003). The duration of residence in the new country and spousal status after immigrating are also significant risk factors that can lead to DV among Arab women (Abu-Ras, 2007), especially if they lack support systems in their new country of residence. Traditionally, marriage continuity and holiness of the family are emphasized in the Arab culture, along with the family's desire to save face over any conflicts in the marriage (Abu-Ras, 2007). Thus, those considerations can play a major role in the underreporting of DV cases reported by the victims of Arab women or their family members due to the overvaluing of the continuity of marriage in an attempt to save the family from division. The societal norms and traditional values force many Arab women and Arab immigrant women to remain in abusive marriages to avoid the shame and consequences associated with separating from or divorcing their abusive

partners. The most common consequences faced by battered women include loss of income or financial resources, loss of children's custody, and possible social ostracization and harassment, along with blackmail from their former husbands (Haj-Yahia, 2002).

There is a scarcity of research on IPV rates within Arab societies, and the immigrant Arab community in the U.S. is understudied. Yet, the scarce studies examining the incidence rates of IPV among Arab Americans report higher rates of DV and IPV targeting women from Arab American backgrounds. In a study conducted in Dearborn, Michigan, by Abu-Ras (2007), it was found that 28% of local arrests involving Arab Americans were due to DV acts. Higher prevalence rates of physical DV and partner-controlling behaviors were reported among Iraqi Americans in Detroit, with a 93% prevalence rate (Barkho et al., 2011). Lastly, acquiring a deeper comprehension of the unique risk factors that Arab women face can be informative to clinical psychologists in developing culturally sensitive DV prevention and intervention techniques and strategies that are specifically tailored to this unique population.

The discussed levels of risk factors, including individual-level, family-level, community-level, and societal-level factors, all play important roles in the continuation of the cycle of abuse. Thus, it is crucial to comprehend the uniqueness of these multi-leveled factors among Arab women for more effective treatment approaches and interventions when working with them. Recognizing the cultural identity of Arab women and the importance of family reputation and wholeness is crucial to recognize before working with them, as it explains their approaches to dealing with DV and their choices when it comes to addressing it. As important as it is to discuss the risk factors that lead to the prevalence of DV among Arab women, it is of more importance to discuss DV protective factors that Arab women would be capable of safely utilizing to prevent or early intervene with their experiences of DV. The next section discusses the under-researched

area of protective factors among this study's population and how it ranges from social support and family ties to a woman's economic capital including education and a career to be factors that can mitigate the reoccurrence of DV experiences to prevent women from exposure to IPV altogether.

Cultural Norms and Beliefs Impacting DV

Middle Eastern Culture and Arab Culture Norms among Arabs and Arab-Americans

According to the U.S. Department of State (2021), about 3 million Americans claim Arab ancestry. Middle Eastern and Arab are often used interchangeably with the misconception that they both refer to the same culture or describe individuals from the same region. However, the Middle Eastern and Arab cultures are two distinguished cultures that may share similar languages, customs, and traditions due to their approximate geographical locations. In order to discuss their similarities and differences, we first need to define each term separately. The term Arab identifies the ethnolinguistic category of individuals who speak and share the Arabic language with different spoken dialects and come from ethnically diverse backgrounds.

The term Arab typically describes individuals who reside in any of the 22 countries that make up the League of Arab States. Although individuals from these countries may speak the Arabic language, they might not identify themselves as Arabs as they descend from other non-Arab ethnic backgrounds (TeachMideast, 2017). On the other hand, the term Middle East is a Eurocentric geographic term that was only coined by the British in the nineteenth century to describe the area between the British colony of India, the Balkans, and the Western part of the Ottoman Empire or modern-day Turkey (TeachMideast, 2017). The Eurocentricity of the term comes from the region being east only from the perspective of Western European countries and not any other countries. The Middle East, or Middle East and Northern Africa (MENA) consists

of a variety of countries that make up North Africa, including Algeria, Tunisia, Morocco, Libya, and Egypt, and the countries to the Middle East of Europe, including Lebanon, Syria, Palestine, and Jordan. Historically, the Middle East has been a predominantly Muslim region that shared a common cultural and religious heritage with the Arab world (TeachMideast, 2017). According to Northwestern University in Qatar [NU-Q] (2018), the Arab countries range between conservative and more liberal; however, most Arab countries identify as culturally conservative, except for Lebanon, which equally identifies as both conservative and progressive. In Jordan, Qatar, and Saudi Arabia, seven in ten individuals identified as either somewhat or very culturally conservative, while the frequency was six in ten Egyptians (NU-Q, 2018). The same survey has also found that older Arab individuals were more inclined to self-identify as more culturally conservative relative to younger Arab individuals, while younger Arabs were three times more likely to identify as progressive than older Arabs (NU-Q, 2018). Although these findings can give hope for the newer generations of Arab women, as the more progressive new generations of Arab men may support them in challenging the cultural beliefs, social norms, and gender norms in the Arab culture, leading to the prevalence of DV among Arab women, these findings do not guarantee Arab women their rights or safety when faced with their abusers.

The findings about the higher statistics of Arab individuals self-identifying as progressive still do surpass the numbers of conservative Arabs, and the same survey has found that both conservative and progressive Arabs still share the same attitudes about preserving the cultural traditions (NU-Q, 2018). Therefore, psychoeducation and raising awareness on some of the harmful cultural traditions and beliefs that lead to the prevalence of DV in Arab societies are needed in order for Arab women to experience the progressiveness of the younger generations that are now more vocal in the society. It is also crucial to recognize that Arab societies are still

considered conservative compared to the Western world today, affecting women's status and how they live under the consequences of male supremacy beliefs. These beliefs cause the DV rates and issues to continue as they innately give men the privilege to discipline women and treat them like second-degree citizens (Kisa et al., 2021). Also, having male supremacy beliefs in Arab society, along with the early marriages of minor girls and young women, not only leads to forced, unsuccessful marriages but also leads to many DV cases and even honor killings, consequently (Kisa et al., 2021). Patriarchal cultural norms and family honor being tied to the women of the family are two structural cultural factors that result in the prevalence of IPV targeted towards women identifying as Arab-American (Kulwicki et al., 2015). Studies have also shown that as Arab women submit to the cultural gender roles in marriage, their experience of IPV and view of it start to get influenced to the extent of preventing them from seeking professional help and IPV supportive services (Aswad & Gray, 1996; Kulwicki, 2000).

In a study by Abu-Ras (2007), 67 Arab American women were interviewed to examine the cultural beliefs that play a role in help-seeking and help-avoiding behaviors among battered Arab women in the U.S. It was also hypothesized that the traditional attitudes Arab women bring with them to the U.S. cause them to become targets of DV and less likely to seek services that support victims of DV (Abu-Ras, 2007). The study findings indicated that 49% of the participants reported being financially dependent on their husbands as their primary source of income (Abu-Ras, 2007). These findings align with the cultural gender expectations within Arab communities, in which men are the primary providers of the household, contributing to the financial abuse experiences encountered by many Arab women.

Patriarchal beliefs and cultural beliefs, such as those related to gender roles, help-avoiding behaviors, and financial dependency, are the main Arab cultural norms and beliefs

discussed in this section to explain how these factors play a role in causing Arab women to become targets of DV as well as being less inclined to seek supportive services during or after their DV experiences. These Arab cultural norms and beliefs extend to include some severe forms of DV, including Female Genital Mutilation/Cutting (FGM/C) and honor-based violence against Arab women. Therefore, FGM/C and honor crimes are briefly discussed in the next section to shed light on their continuing practice in some Arab regions to our present day. These two cruel forms of DV not only result in the previously discussed DV effects, but they also lead to Arab women losing their lives in order for their families or partners to continue living by the societal norms.

The therapist's knowledge of these cultural similarities and differences between the Middle Eastern and Arab cultures can aid in the building of therapeutic relationships with clients from these cultural backgrounds. It is particularly important to differentiate between both cultural backgrounds to gain a deeper insight into the distinct risk factors leading to DV and the beliefs that result in Arab women staying in abusive relationships. This knowledge and awareness can help to prevent countertransference-related issues as well as any rupture in the therapeutic relationship due to the clinician's limited awareness and unfamiliarity with the client's cultural values, customs, belief systems, and societal norms.

Female Genital Mutilation/Cutting (FGM/C) & Honor Crimes as Forms of DV against Arab Women

The United Nations (UN) and the WHO acknowledge Female Genital Mutilation/Cutting (FGM/C) as a detrimental custom that breaches the human rights of girls and women across the world (United Nations' Commission on Human Rights et al., 2008).Over 120 million females have unfortunately undergone the barbaric practice of FGM/C, and 2 million girls are still at risk

of getting this practice done to them every year (Refaat, 2001). Musteshi et al. (2016) described how the practices of FGM/C can take different forms that include cutting, pricking, removing, and sewing up parts of the external female genitalia for reasons other than medical necessity (Musteshi et al., 2016). FGM/C is a traumatizing experience for many girls and women who undergo it, leaving behind psychological pain that lingers beyond the physical pain and affects their mental health for the long term (Mustehi et al., 2016). The mothers who decide to make their daughters undergo this practice were found to view it as normal and even essential for their marriages (El-Zanaty & Way, 2006). Older women's views of the FGM practice as a beneficial practice for their daughters' future marriages, rather than a form of physical abuse against their daughters, explain the continuation of it in many Arab and Middle Eastern countries until our current day. A study carried out by Refaat et al. (2001) found that Egyptian women who had undergone the practice of FGM were more inclined to accept and not condemn wife-battering and justify it. The immediate bodily harm of FGM extends beyond severe pain and bleeding to include complications such as sepsis and difficulty in urination and feces passage, as well as infections (Muteshi et al., 2016).

Honor crimes also still occur in most Arab countries due to the cultural notion that women reflect the family's honor and dignity. Honor crime is defined as a violent act that is carried out by male relatives against women in the family due to perceiving their actions as breaching the family's honor (Kulwicki, 2002). The concept of honor is what the male partners and family members use to rationalize the extreme violence against and killing of women, tying it to the notion that the family's honor depends on the woman's behaviors (Baker et al., 1999). Most Arab countries still have lenient laws to deal with honor crimes due to the cultural traditions and customs that justify the practice of killing women for not "keeping the honor of the

family". Honor crimes or killings are committed against girls or women due to their engagement in socially disapproved sexual behavior, and those disapproved sexual behaviors are often specific to the community and even family that they vary from sex outside marriage to even being raped (Heydari et al., 2021). The women that transgress their family's or community's traditions are also seen as dishonoring their families and these traditions (Heydari et al., 2021), resulting in even more incidents of honor crimes against Arab women.

FGM/C and honor crimes are extreme forms of DV that continue to be used against Arab women in different Arab countries. Despite FGM/C being recognized as a detrimental practice by the United Nations (UN) and the WHO, it is still a prevalent practice among conservative Arab societies that some Arab governments are moving towards criminalizing due to the dangers of that barbaric practice. On the other hand, honor crimes are still practiced in many conservative Arab societies for non-sexual behaviors by women such as simply not following family or community traditions as it is deemed to be disrespectful to the family therefore these crimes are viewed as forms of restoring the family honor. These extreme forms of DV specific to the focus population of study along with the previously discussed DV forms clarify the differences between the severity of DV among Arab women compared to Western women. And that leads to the discussion of the most commonly used DV interventions in the next section. The battered women's movement is discussed in light of recognizing how and why the changes in the DV therapeutic interventions started. The commonly used interventions for DV victims of women are not limited to therapeutic approaches used with women on the individual level but rather include community-based approaches. The emerging community-based approaches are discussed as they are the growing IPV interventions used for children and adults who have experienced DV. These approaches also focus on early prevention of IPV through psychoeducation on gender

equality for children, reduction of externalizing behavior in IPV perpetrators to reduce risk factors for women, and structured therapy for IPV victims of women to reduce dire effects of witnessed abuse.

Acculturation Among Arab Americans

Acculturation is broadly described as the process through which individuals acclimate and integrate into a new host culture (Amer & Hovey, 2007). Acculturation is also the process by which immigrants in any new host country attempt to assimilate into that country's mainstream culture (Suleiman et al., 2021). Although acculturation is often referred to as the process of cultural change, acculturation is also a process of psychological shift occurring due to the member's exposure to two distinct cultural communities (Jadalla et al., 2015). The acculturation process is unique to each cultural group, and it depends on numerous variables, including cultural and sociopolitical variables of both the immigrant and the host or majority group (Berry, 2003). The four ways in which immigrants acculturate to a country's mainstream culture are assimilation, integration, separation, and marginalization, as proposed in Berry (2003), one of the most widely recognized models of acculturation (Berry, 2003 as cited in Jadalla et al., 2015). Immigrants who assimilate to a new culture and ultimately acquire the dominant culture with a lack of interest in maintaining their own culture (Berry 2003, as cited in Jadalla et al., 2015). Unlike assimilation, integration is the process by which immigrants embrace and integrate both their ethnic culture and the values and practices of the new environment and culture. Separation is the immigrants' strategy to maintain their ethnic culture while avoiding or rejecting contact with the dominant host culture. Lastly, marginalization is the voluntary or involuntary exclusion of immigrants from their ethnic and dominant culture (Chun et al., 2003, as cited in Berry, 2003).

Acculturation can be a positive or negative experience for immigrants who go through it, and it can have either positive or negative impacts on their mental health, depending on the process or strategy through which acculturation occurs. Adaptation to a new host culture successfully includes many factors and resources that shape the acculturative process, such as generational status or age, education level, problem-solving style, and social support (Amer & Hovey, 2007). When acculturation occurs through successful psychological adaptation to the host society and its culture, the acculturating individual cultivates a robust sense of identity, self-esteem, and overall psychological wellness. Conversely, negative adaptation arises when the acculturation process results in identity confusion and anxiety in the acculturating individuals (Castro, 2003, as cited in Amer & Hovey, 2007). Positive adaptation and psychological outcomes of acculturation can be predicted by the individual's acculturation strategy similarity to the acculturation approach chosen or imposed by the host culture on them (Castro 2003, as cited in Amer & Hovey, 2007). When examining the immigrants' acculturation strategies, it is crucial to consider the influence of the host country's or community's reactions and attitudes towards the acculturating group (Amer & Hovey, 2007).

Research has shown that the integration strategy of acculturation is tied to the most favorable psychological effects in acculturating individuals due to its association with the social support received from ethnic and mainstream cultures (Amer & Hovey, 2007). Literature has shown inconsistent results regarding the benefits of integration; it has demonstrated maladaptive outcomes in acculturating adults, such as acculturative stress, the stress imposed on individuals by the challenging demands of the acculturation process (Rudmin, 2003, as cited in Amer & Hovey, 2007). Acculturation stress has been found to be directly related to the acculturation strategy followed or chosen by individuals. Therefore, integration was found to be associated

with lower acculturation stress levels, while marginalization was associated with the highest acculturation stress levels (Bourhis, 1997). Furthermore, research studies found separation to be related to higher stress levels than assimilation (Bourhis, 1997). Acculturation stress occurs as a result of different challenges and factors experienced by the acculturating individuals, including new customs, unfamiliar norms, language, and laws, along with the prejudice and discrimination they face in the host country (Chun et al., 2003, as cited in Amer & Hovey, 2007). Individuals with high levels of acculturation stress also tended to exhibit different psychological symptoms, including identity confusion, depression, anxiety, suicidal ideations, and even somatic complaints (Castro, 2003; Hovey, 1997).

Acculturation and its effects on mental health patterns among the Arab American population have been understudied, as most research focuses on larger immigrant and minoritized populations within the U.S. (Amer & Hovey, 2007). The acculturation process and the acculturation stress that comes along with it are important to consider when working with immigrant minority women, such as Arab women, as they may influence the immigrant women's help-seeking behaviors and ultimately become barriers to seeking help (Brabeck & Guzman, 2008). Previous research has also found that low levels of acculturation among immigrant women indicate less likelihood of seeking help and public services (Lipsky et al. 2006). Understanding the role acculturation plays in the prevalence of DV among the population of Arab American women can aid in understanding the complexity of the various variables that contribute to and result in experiencing IPV. The intersection of identities among immigrants of Arab women is further proof that the experience of IPV is not uniform, even among women from the same ethnic background. The acculturation process comes with new life circumstances and situations that can contribute to immigrant women remaining in their abusive relationships (Kim

& Sung, 2001). These new life conditions and circumstances entail experiences that are linked to IPV prevalence among immigrant women, such as the struggle to obtain employment, resulting in immigrant families suffering financially and interpersonally with the men of the households facing the stress of not fulfilling their primary roles as primary financial providers for their families (Wallach et al., 2010).

The acculturation process for immigrant women is often characterized by different help-seeking barriers that include but are not exclusive to their loyalty to family cohesion, fear of breaking family expectations, and concerns about deportation, which make it progressively challenging for many immigrant women to seek any form of professional help following DV incidents (Brabeck & Guzman, 2008). These help-seeking barriers prevent women from receiving the help they need and can result in various psychological issues and difficulties, including depression, anxiety, social withdrawal, and PTSD among immigrant women (Bonomi et al., 2009). Although white women and immigrant women may experience similar physical and psychological consequences to IPV, immigrant women are also faced with the disadvantages that come with their immigration status, including their limited access to resources, lack of social support, discrimination, tolerant and justifiable attitudes towards IPV, and language proficiency levels of their host country. These accumulated factors make it more complicated for immigrant women to break the cycle of violence and seek help when experiencing IPV.

Acculturation is a long and complicated process that immigrants face as they settle into their new host country. The majority of immigrants adopt one of the main acculturation strategies—separation, marginalization, assimilation, and integration- when moving into a new country of residence. Depending on the acculturation strategy followed by the immigrant individuals, the consequences change to make it less or more challenging to settle into and

establish a new life in the new country of residence. Immigrant Arab women are no exception to facing obstacles that are often endured in new host countries, which include a lack of social support, limited awareness of available resources, language barriers, fear of deportation, and various stressors associated with the acculturation process. These acculturation factors, along with individual factors, such as cultural ideas and beliefs about IPV, are central to reinforcing the cycle of violence and prevalence of DV among immigrant Arab women.

Factors Influencing DV Among Arab Women

DV Protective Factors Among Arab Women

Domestic violence and its effects, risk factors, and protective factors remain understudied in most of the Arab world. Thus, exploring these aspects of DV is important in protecting Arab women and their rights. In countries with higher income, the presence of supportive social networks was shown to mitigate the negative impacts associated with IPV on women's psychological issues, such as manifestations and signs of depression and anxiety (Mburia-Mwalili et al., 2010). The type of connection between married women and their natal families has been found to affect whether women view their families as a part of their social support system or not when it comes to their experience of DV. Some studies have found that women maintaining strong ties with their family of origin tended to report fewer incidents of IPV (Naved & Persson, 2008). However, other studies have found that the presence of social support does not necessarily have an impact on less occurrence of IPV (Jeyaseelan et al., 2004). Although these disparate results can be stemming from the differences in the measures employed across the various studies to evaluate for DV risk factors, the factor of family unsupportiveness and their level of adherence to the Arab societal gender roles and traditions remains a contributor to the recurrence of DV experiences among Arab women despite any discrepancies in assessment tools.

Many studies have found education to be one of the main protective factors and indicators of the lower likelihood of women undergoing IPV (Shaikh et al., 2016). Research by Vakili et al. (2010) suggested that utilizing education as a strategy could contribute effectively to the prevention of IPV. Married Egyptian women who had closer ties with their families and relatives were found to have a lower likelihood of experiencing physical IPV (Yount & Li, 2010). The investment in the social and economic capital of women before marriage among Egyptian women is also considered a mitigating factor to being exposed to IPV, suggesting that having support systems, including family, career, and financial independence, are protective factors against DV. In other studies, done among Egyptian women, women who were subjected to maltreatment by their parents were found to have an increased risk of encountering physical abuse (Jeyaseelan et al. 2004; Yount & Li 2010).

Although DV protective factors among Arab women remain understudied compared with Western women, the discussed protective factors in this section, such as education, family ties, career, and social and economic capital, are major factors that have been found to be protective to Arab women against experiencing DV or IPV. The discussion of DV protective factors brings up the societal norms and factors that can contribute to experiences of DV among Arab women. In the next section, the Arab societal norms are discussed, along with the religious factors that may play a role in the higher DVA prevalence rates among Arab women. The discussion of Arab societal norms is crucial in having more culturally sensitive clinicians by providing them with the full picture of the norms that Arab women learned to follow unchallenged or unquestioned in order to continue receiving social support or being included in society, which eventually led to the continuous abuse and unbroken violence cycle among this population.

Cultural Influences Impacting DV

Religion has a major influence on the persistence and frequency of DV rates among Arab women, sparking debates regarding women's status and male control over women. These debates occur when Islamic doctrines get misinterpreted, and the social norms become confused due to being linked to the misinterpreted religious doctrines, contributing to the frequency of DV towards Arab women (Elghossian et al., 2019). Age was also found to be a strong predictor of DV, with a higher likelihood of experiencing IPV observed among younger women (Kazzaz et al., 2019).

Along with religion, the age of marriage in religious societies, the number of children, SES, and marriage duration were also found among the factors heightening the probability of women experiencing DV (Saffari et al., 2017; Zakaliyat & Susuman, 2018). The majority of Arab countries remain patriarchal societies that are predominantly masculine and follow gender roles to a great extent, with large gender gaps still experienced by women today. In some Middle Eastern and Arab countries, such as Iran and Saudi Arabia, religious rules are still embedded in their national civil laws, which has a significant impact on the society's perception of DV as well as women's perception of DV as a justifiable act or an act that they cannot escape from due to the national laws not protecting them (Aghatie, 2016). Another risk factor for DV that studies have recently suggested is the unusual less or more schooling earned by the wife compared to her husband (Yount & Li, 2010). This difference can be due to many societal factors including the gender norms that the husband is expected to be not only the breadwinner but also more highly educated than his wife, the husband's low self-esteem due to his wife's higher educational degree, or the pushing of the gender norms by family members on the husband.

The general lack of cultural support for women in the Arab cultures along with the dependence on males in marital relationships for financial stability, specifically following the

immigration to a new country, are societal norms that cause IPV among Arab women (Kulwicki et al. 2015). The latter societal norm can be a leading factor in financial domestic abuse among immigrant Arab women as they settle down in their new residing country with no means of supporting themselves but depending on their intimate partners to provide for them and their families. Many Arab societal norms are shared across the Arab world as the countries in that region share similar cultures and traditions; however, there are some societal norms specific to each country's culture and its civil laws. These society-specific Arab norms are often seen in Arab countries that are more conservative and have religious rules embedded in their civil laws, such as Saudi Arabia and Iran. These laws' leniency towards the DV abusers allows DV to continue being viewed as a private and justifiable act against Arab women in their societies to this day. The same laws are also among the main factors that lead to DV and its high prevalence rates among Arab women, as the abusers receive no deterrent consequences for their actions. The discussed factors, including the age at marriage, SES, marriage duration, and a larger number of children, are all factors that were found to increase the likelihood of experiencing DV among Arab women.

The next section explores the various effects women suffer from due to their exposure to DV, and it discusses how the effects of DV are similar across women. Just like how DV extends beyond physical abuse, the effects of DV also extend beyond the physical injuries it may cause. Therefore, the next section attempts to discuss in depth the unspeakable emotional, psychological, and sexual effects of DV on all women and how these effects manifest among this study's focus population of Arab women.

The Various Effects of Domestic Violence

The dire effects of DVA are unfortunately not limited to physical injuries and their consequences. Domestic violence's effects extend beyond the physical well-being of its victims, and it has a ripple that extends beyond impacting the individual level. Violence against women has been found to impact women's physical and emotional health, and numerous previous studies have shown that DV has led to adverse mental health and psychological consequences, including depression, anxiety, and suicidal ideation (Haj Yahia, 1999). In a study that surveyed 140 Tunisian married women, it was found that there is a strong correlation between depressive disorders and wife abuse (Cheour et al., 2001, as cited in Douki, 2007). Among Egyptian women, IPV corresponded with elevated levels of depression and anxiety (Douki et al., 2007). In studies by Ahmadzad-Asl et al. (2016) and Al-Faris et al. (2013), anxiety and stress were also found to be two major effects of DV impacting North African and Middle Eastern women, while Akyazi et al. (2018) highlighted the elevated stress levels experienced by battered women. A few studies linked the frequency of witnessed DV by women to the increased use of contraceptives (Diop-Sidibe et al., 2006), and the same women had reduced attendance for their antenatal care visits as reported in studies by Alan et al. (2016) and Barnawi (2017). According to Ibrahim et al. (2015), DV was also found to lead to fetal distress and even fetal death. The ripple effect of domestic violence on its victims' lives extends to affect the victims' ability to disclose the violence or access support to end the abuse. Thus, the victims might end up having difficulty accessing any social support systems or services, forcing them to stay in that cycle of violence and abuse.

The physical effects that are caused by domestic violence are more severe than just physical injuries of fractures, a black eye, or concussions in many cases (Coker et al. 2002). Many women who experienced domestic violence also reported chronic pain that was not

explainable and not in areas of the abuse (Sugg, 2015). In attempts to describe chronic pain, it was described to include chronic fatigue, bleeding, and sometimes experiencing painful intercourse with their abusive partner. Women who experienced DV were also at an increased risk of suffering from depression, anxiety, antisocial behavior, low self-esteem, social isolation, PTSD, and having higher suicide rates compared to other women (Sugg, 2015; Kisa et al., 2021). Domestic violence impacts extend beyond diminishing the victim's self-esteem to also diminishing their capacity to end the violence cycle and break free from their abusers (Walker, 1977-1978). In a study by Wuest et al. (2008), 31% of survivors of DV were found to have engaged in one suicide attempt at one point in their lifetime. Victims and survivors of DV not only suffer from the physical and emotional scars, but they are also left with low self-esteem, isolation from society, and even their loved ones due to the shame associated with DV, fears for their lives, and the co-occurrence of such traumatic experiences and increased suicidal ideation. The effects of IPV in households with children are even more drastic, as it not only impacts the mental health of children negatively but also can cause dire long-lasting effects on their development and well-being as a result of witnessing violence and living with the fear of its reoccurrence. The fear of being DV revictimization can be a common symptom experienced by most DV victims and survivors, and it can also be seen in children who live through similar experiences, regardless of their witnessing or experiences of DV and IPV.

Physical effects of DV are often discussed first as the main DV effects when talking about DV; however, DV effects extend beyond physical injuries. Domestic violence has drastic effects on its victims' mental health, emotional health, and sexual health. The psychological effects of DV are not limited to depression and anxiety that result from the terrorizing abuse from a family member or a partner, and these extend to include more severe effects on the

victims' mental health, such as suffering from low self-esteem, social isolation, suicidal ideation, and higher suicide rates in comparison to women with no history of DV experiences. It is also crucial to recognize the ripple effect of DV that extends beyond the individual level of its victims to also include their children and other family members who can either be witnesses of the violence or the victim's suffering through it. The next section takes into account the previously discussed sections of the Arab societal norms and religious factors leading to DV to introduce the preserved Middle Eastern and Arab norms among Arabs and Arab Americans. The purpose of this section is to investigate the passed-on Arab cultural norms that continue to contribute to higher DV prevalence rates among Arab and Arab-American women. Patriarchal cultural norms and women's carrying of the family honor beliefs are argued to be some of the normalized beliefs that lead to the prevalence of this human rights issue among both Arab and Arab American women.

Interventions for DV

General Interventions Utilized with DV Victims of Women

Interventions for DV address multiple different aspects of IPV besides physical abuse, including safety, immediate and lasting consequences, trauma processing, and re-victimization (Condino et al., 2016). The battered women's movement, which emerged during the 1970s, is considered the catalyst for changes in the therapeutic interventions used for DV, along with the growing understanding of the criticality of DV as a health issue that compromises the safety of its victims (Schechter, 1982). The grassroots movement fought to obtain government funding for domestic violence shelters in order to provide more services for IPV victims and raise public awareness about IPV (Schechter, 1982). This change in ideologies and awareness about IPV resulted in a shift in the interventions for DV victims from victim-centered to perpetrator-

centered (Hackett et al., 2015). This paved the road for different group therapy approaches for both the perpetrators and victims to be utilized in the treatment of the effects of DV (Danis, 2003). The community-action approach is one of the most expanding and encouraging IPV interventions used to address IPV for children and adults. A study by DePrince et al. (2012) has demonstrated that community-based outreach resulted in reduced levels of distress reported by IPV victims. A similar study conducted by Graham-Bermann et al. (2007) employed an alternative community-based intervention with children exposed to DV and found that the intervention resulted in diminished occurrences of internalizing and externalizing behaviors in children. The same community-based intervention approach has been used for an IPV offenders' program informed by the ecological model framework (Heise, 1998), and the program focused on diminishing risk factors while enhancing protective factors associated with violence towards women by analyzing the individual, interpersonal, situational, and social factors of the offenders' (Lila et al., 2010).

Psychologists in Europe and the U.S. have been conducting research, clinical evaluations, and interventions to contribute to the prevention of IPV (Condino et al., 2016). Some of the most effective DV prevention projects are led by the *Asociación de Asistencia a Víctimas de Agresiones Sexuales y Violencia de Género* (ADAVAS), and they aim at reducing the risk of sexual abuse through raising gender equality awareness among children and adolescents (Condino et al., 2016).

The different types of programs addressing DV offer women a variety of services utilizing approaches that speak to the victims or the abusers. For example, Condino et al. (2016) discussed how ADAVAS has implemented programs consisting of support groups for women who experienced DV. In the United States, Canada, and the United Kingdom, interventions and

therapeutic programs addressing DV often include compulsory programs for the abusers, utilizing a pro-feminist approach to emphasize and deconstruct the violence associated with male strategies of power and control over women in their relationships (Adams, 1989; Pence & Paymar, 1993). The research literature supports the use of counseling and structured therapy as interventions to reduce the negative effects of DV that go beyond physical injuries, in particular, PTSD and depressive symptoms (Eckhardt et al., 2013). In most IPV interventions and support groups, participants are not directly encouraged to end their abusive relationships but are rather educated on their rights and empowered to take control of their lives (Condino et al., 2016).

Interventions for IPV exist across different medical and mental health settings, and they utilize various treatment modalities, often emphasizing follow-up care post-discharge from the DV shelters (Condino et al., 2016). One of the most prevalent modalities in IPV interventions is CBT, and the two notable CBT programs often utilized to support DV survivors of women are Cognitive Trauma Therapy for Battered Women (CTT-BW) developed by Kubany et al. (2003, 2004) and the Helping to Overcome PTSD through Empowerment (HOPE) program for managing trauma symptoms resulting from DV experiences (Johnson et al., 2011). CTT-BW is a multi-component trauma-focused cognitive therapy intervention designed to address PTSD symptoms in women who encountered physical and/or sexual abuse at any stage of their lives (Kubany et al., 2003, 2004). CTT-BW works on the roles of guilt and shame beliefs associated with IPV that result in maintaining PTSD symptoms, using cognitive-behavioral techniques such as psychoeducation, stress management, cognitive restructuring, and exposure-based interventions (Kubany et al., 2003, 2004). These CTT-BW cognitive-behavioral-based interventions aim to use self-monitoring along with cognitive restructuring techniques to address the negative self-talk and self-blame experienced by most IPV victims and survivors of women

(Kubany et al., 2003, 2004). CTT-BW is usually 8-11 sessions of individual treatment with women who have been out of their abusive relationships for at least 30 days, have no intentions of reestablishing relationships with their abusive partners, and have met the diagnostic criteria for partner-abuse-related PTSD (Kubany et al., 2004).

The HOPE program is another brief treatment program of 9-12 sessions for battered women that utilizes CBT-based interventions for female shelter residents (Johnson et al., 2011). The HOPE program focuses on supporting women in accurately evaluating the DV threat level when exposed to it and providing women with techniques and skills to effectively manage their PTSD symptoms without compromising their safety (Johnson et al., 2011, 2016). Similar to the CTT-BW, the HOPE program provides psychoeducation about IPV, PTSD, and safety planning for IPV women survivors (Johnson et al., 2011). One primary focus of the HOPE program is emphasizing the need to work in collaboration with DV case managers and other resource providers, as emphasized in Johnson et al. (2011), as a means to strengthen the program's core principles related to empowering women. The newly adapted iteration of the HOPE program expands to include six more sessions following the shelter stay in addition to the main 10 sessions conducted during the stay at the shelter to re-evaluate the goals and safety of women participants and reinforce the previously learned treatment interventions (Johnson et al., 2016).

The efficacy of Interpersonal Therapy (IPT) for low-income pregnant women who were victims of IPV was examine in a study by Zlotnick et al. (2011). The results indicated moderate effectiveness of IPT in reducing PTSD and depression symptoms during pregnancy as well as large effects in reducing PTSD symptoms in women up to three months postpartum. In another study by Cort et al. (2014), the findings of IPT treatments indicated positive posttreatment

interpersonal functioning changes and a reduction in the severity of depression symptoms in women with IPV histories.

According to Wang et al. (2005, as cited in Cort et al., 2014), IPT administered in a community agency was found to be much more well-received by women participants, as evidenced by treatment completion rates than in traditional outpatient mental health clinics. This finding suggests that the type of treatment setting can play a role in accepting new treatments by women with IPV histories. IPT groups for women survivors of IPV have also proven their efficacy in alleviating depressive symptoms as well as facilitating the development of social skills among women participants (MacKenzie & Grabovac, 2001).

Women who developed depressive and PTSD symptoms due to their exposure to interpersonal trauma have been found to have a greater vulnerability to encountering future instances of IPV (Iverson et al., 2011). This finding gives prominence to the limitations and reduced efficacy of IPV interventions targeting perpetrators in addressing the psychological effects of IPV, as it can be interpreted as victim-blaming among IPV victims of women (Dutton, 2009). Due to the implication of depressive symptoms as risk factors for general IPV revictimization, Cognitive Processing Therapy (CPT), a modality utilizing cognitive behavioral therapy principles that was found to be beneficial in reducing depressive and PTSD symptoms, has been utilized among women with IPV histories (Iverson et al., 2011). The goal of the study by Iverson et al. (2011) was to examine the association between the reduction of depressive and PTSD symptoms due to engagement in treatment and future IPV revictimization among women with histories of IPV. The study results have found that women who exhibited less severe depressive and PTSD symptoms during the CPT treatment period reported fewer incidents of IPV at a six-month follow-up relative to women without treatment exposure (Iverson et al.,

2011). This study opens the door for experimenting with more psychological interventions in hopes of preventing future IPV among women with IPV histories, as the interventions help in reducing the negative psychological effects.

The discussion about the commonly used IPV interventions is better explained and understood through the catalysts of the movement for battered women and the grassroots movement, which allowed for the research and development of IPV interventions and provided women with safe DV shelters. The literature in this section also indicates that the discussed community-based approaches, such as the CTT-BW and HOPE programs, which provide women with support and empowerment through therapy and other resources, have been found effective in lowering distress levels among IPV victims. The different therapy approaches of CTT-BW, IPT, and CPT have been found to reduce the negative psychological effects of IPV in women as indicated in the reduced reported symptoms of depression and PTSD among victims and survivors of women. These IPV intervention approaches have also been found to facilitate self-esteem and social skills among women as well as reduce guilt and shame beliefs associated with speaking up about IPV. Although the discussed IPV intervention approaches are commonly used across settings and populations of women worldwide, it is crucial to consider whether these approaches would be culturally appropriate for the population they are used on. The interventions with DV victims of Arab American women section discusses the role that the immigration status and marginalized identities of these women play in putting them at a disadvantage when it comes to having fewer human resources and social networks, placing them at an increased risk for encountering IPV.

Interventions with DV Victims of Arab-American Women

Immigrants face multiple challenges as they move to settle in a new country, and their challenges in their new country of residence are influenced by different factors that they bring along with them, including their SES, educational level, religious beliefs, and traditions. The study by Bui and Morash (1999) has shown that immigrant women who come with disadvantages in social status and human resources exhibit lower chances of active participation in social networks compared to immigrant men (Abraham, 2000). This finding may serve as a risk factor contributing to higher rates of DV among immigrant Arab women. It can also explain subsequent inequalities and limited access to culturally sensitive and safe social and mental health services. Arab immigrants bring their sociocultural norms and practices to the U.S., making the reporting of DV incidents difficult and even life-threatening for the DV victims to reach out for help beyond the circle of their family and acquaintances from the same cultural background. In other instances, immigrant Arab women may have access to mental health and social services, yet they may not have the final decision and autonomy in accessing these resources safely (Menjívar & Salcido, 2002). Although the difficulty of accessing supportive resources may stem from the shame and social stigma connected to seeking legal or psychological services, it can also be a direct result of the limited social networks and self-isolation experienced by women due to their immigration status.

Among the Arab-American community in Michigan in 1993, there were 34,505 domestic violence and assault cases and 45 homicide cases involving a form of domestic violence reported (Michigan Department of State Police, 1993). A 1994 report from the Michigan Department of Public Health's Task Force on Interpersonal Violence Prevention and Reduction highlighted that DV occurs at elevated rates among minority populations and results in a higher rate of fatalities than is observed in white American communities. Despite the higher DV rates among Arab

immigrant women, Arab women remain averse to seeking or receiving social services and interventions in IPV cases. This is evident through the notably low rates of DV incident police reports filed by Arab women (Aswad & Gray, 1996). The reluctance of Arab American women to seek psychological and social services following their DV experiences can be due to the expectations put on Arab women within the Arab immigrant community to follow traditional values regarding marital and gender-role expectations (Abu-Ras, 2007). Although the cultural expectations placed on Arab women can be leading factors to their aversion to seeking different supportive services, the fear of discrimination and lack of culturally sensitive interventions in both legal and mental health services remain strong barriers to seeking the available IPV supportive services by Arab Women (Barkho et al., 2011). Language can also be another barrier to utilizing IPV supportive services, making it crucial to employ professionals who can speak the language of the populations they serve. Thus, it is not only seen as shameful but also a betrayal to divide the family by speaking up or reporting their DV incidents.

Research and previous studies suggest that the prevalence rates of DV among Arab women are more elevated than the DV rates around the world. The national laws, the gender roles, the social life and factors, and the religious doctrines that are still followed put Arab women in a position more prone to experiencing domestic violence. These same laws, doctrines, and traditions make it harder and more dangerous for Arab women to disclose their DV experiences or seek help from a professional. Thus, psychoeducation about DV and its effect on women's bodily health and emotional well-being would be an important intervention to empower and educate women regarding their rights. Psychoeducation about the available resources that women can access and the type of support each resource provides would also be crucial to provide Arab women, to ensure their safety.

In many Middle Eastern countries, DV remains considered a family matter, and it is not treated as a critical public health concern or a legal issue (Kulwicki & Miller, 1999). As with many immigrant communities, Arab women within the Arab immigrant community are still expected to adhere to the traditional values concerning marital and gender-role expectations (Abu-Ras, 2007). In the Arab immigrant community across the U.S., the anti-Arab political climate following 9/11 also had a major impact on deterring Arab immigrant women from seeking any social or professional services, including contacting the police, in fear that it may provoke political harassment towards them and their family members (Abu-Ras, 2007). Thus, providing Arabic-speaking professionals or professionals with similar cultural and ethnic backgrounds as Arab women may help draw Arab women towards seeking those types of services, as they would feel safer and more relaxed talking to professionals who understand their cultural traditions, norms, and beliefs.

The immigration status of Arab women in American society indeed plays a major role in shaping and even limiting the support-seeking attitudes of Arab women victims of DV. That can be directly attributed to the immigration status they hold, limiting their human resources and social networks. Also, the shame and guilt surrounding speaking up about DV, which means speaking up against a partner or a family member, are the cultural norms that keep the cycle of DV among women. The same shame and guilt surrounding speaking up about IPV also surround help-seeking behaviors, which are crucial to consider when choosing DV interventions to use with Arab women victims. Although having knowledge about Arab cultural norms and beliefs when working with Arab DV victims of women would assist in better understanding and building a therapeutic relationship with Arab women, language may remain a barrier, particularly when working with DV victims of newly immigrated Arab women. The language barrier makes

it more challenging for women to utilize or benefit from IPV interventions and resources regardless of their help-seeking attitudes. Therefore, it is of great importance to train Arabic-speaking professionals to not only ease access to resources but also encourage Arab women to seek professional help when exposed to any DV behaviors, which would gradually result in a change in the prevalence numbers of DV among Arab women.

Chapter III

Product Development and Review

Domestic violence and abuse (DVA) can take many forms, ranging from physical, psychological, sexual, verbal, and financial abuse. On average, 20 American individuals, both male and female, get physically abused by a romantic partner, equating to more than 10 million victims and survivors of women and men (VCADV, 2022). According to the WHO (2021), nearly one-third of women globally aged 15 to 49 were involved in an abusive relationship in which they experienced instances of sexual or physical abuse committed by a male partner. The negative physical, psychological, sexual, and productive health effects make the statistics of DV among women more alarming, as these statistics come from only the reported DV cases in developed Western countries and the scarce information about DV in some regions, such as the Arab world, where it is not even safe to report DV in most cases.

Goals of the Project

The main goal of the manual is to educate mental health professionals about the prevalence of DV among Arab women, the cultural values and risk factors contributing to it, and the culturally appropriate resources to utilize in the process of empowering and treating women from Arab backgrounds. The manual also aims to inform mental health professionals about effective intervention approaches for the target population, considering clients' acculturation levels and promoting resilience through psychoeducation about the forms of DV, rights of women, and the negative effects of DV on the bodily and psychological health of women, as well as their overall well-being and social life.

Conceptual Framework

Literature on the Arab cultural context of DV against women is very limited due to the cultural traditions, social norms, religious beliefs, and, most importantly, safety issues faced by women who disclose their DV experiences. Cultural norms are among the main reasons DV victims and survivors are alienated from seeking either legal or medical attention (Kulwicki, 2009). Thus, reliable methods and measures of reporting and recognizing domestic violence crimes against Arab women are scarce.

Domestic violence remains a prevalent issue in most countries around the world. Although its prevalence rates are higher in Arab countries compared to most Western countries, domestic violence remains a serious health issue faced by American women generally and immigrant Arab women, particularly within the U.S. Thus, it is crucial to have a better understanding of the gender norms, traditions, and cultural beliefs of the Arab countries to be able to tackle the prevalent issue of DV against Arab women.

The process of developing the psychoeducational manual required a thorough review of previous research on the issue of DVA worldwide before examining the higher prevalence rates and risk factors contributing to the persisting problem among the population of Arab women. In order to investigate relevant literature and peer-reviewed articles, multiple electronic databases were utilized to perform a comprehensive search and provide a thorough literature review of the dissertation topic, including APA PsycArticles, PsycINFO, PubMed, EBSCOhost, and Google Scholar. The main areas of literature review included definitions of DV and its types, consequences, prevalence rates, risk factors, protective factors, and other external and individualistic factors such as SES, immigration status, and acculturation levels.

Some key terms utilized in the research for relevant literature included domestic violence, intimate partner violence, Arab women, Arab American women, domestic violence risk factors,

domestic violence interventions, acculturation, and immigration to expand searching results to include relevant topics that would cover all the main sections and issues addressed in the psychoeducational manual. Among immigrant Arab women, as with many other immigrant communities in the U.S., traditional values still overrule the values of the new country of residence, whether these values are regarding gender roles, marital expectations, or cultural and religious beliefs. Therefore, it is crucial to consider the types of interventions that would be appropriate to use with survivors and victims of DV, as well as the cultural background of the professionals who will provide battered Arab women with the needed support. The main goal of exploring the types of DV, its prevalence, its risk factors, and its protective factors as it pertains to the population Arab women in the Middle Eastern region and the U.S. is to eventually have enough reliable data on the topic to gather and put together a Domestic Violence Among Arab women and immigrant Arab women Manual of DV statistics, causes, supportive resources, and interventions that battered women can use to support themselves and safely leave abusive situations. The DV manual aims to provide battered women with psychoeducation about the effects that DV has had on their lives, the available safety resources they have access to, and the different interventions that can help them overcome such traumatic experiences at their own pace.

Many people continue to think of domestic violence as a private matter between spouses rather than a criminal offense. Unfortunately, this is the reality for many women who encounter domestic violence, preventing them from reporting their domestic violence incidents and repeatedly falling victim to DV. To be able to change that, the Domestic Violence Among Arab and Immigrant Arab Women Prevention Manual is being developed to educate Arab women on their rights and the resources they can safely seek, provide them with psychoeducation on the

impact of DV on their well-being and their children's, and introduce the interventions that would be culturally appropriate and acceptable to them. It is a psychoeducational tool for clinicians to utilize in training and preparing to work with Arab American women victims of DV to gain a deeper understanding of the cultural background, sociopolitical factors, immigration statuses, acculturation levels, and intersectional identities contributing to the prevalence of DV within Arab societies.

The inclusion criteria for literature to be utilized in the development process of the psychoeducational manual included studies focused of dissecting the IPV issues as gender-based violence and abuse towards women globally, with a greater focus on peer-reviewed articles focusing on Arab and Middle Eastern populations of women and the risk factors they face contributing to the prevalence of the DV cycle. Another significant inclusion criterion was literature discussing culturally responsive DV treatment approaches and programs that are tailored towards addressing DV among Middle Eastern women. The inclusion criteria for mental health professionals' eligibility to review the manual included coming either from a Middle Eastern background or having worked with the Arab population to ensure their understanding of the target population risk factors and their familiarity with the cultural beliefs, traditions, and practices contributing to the prevalence of the DV issue. Exclusion criteria included articles lacking empirical foundation and mental health professionals with no previous clinical experience with the target population.

Product Development

The Domestic Violence Among Arab Women and Immigrant Arab Women Prevention Manual is divided into different sections, with the first section introducing the definition of domestic violence and its different types. This section aims to help Arab women identify if they

have been victims of any form of DV in their lifetime and if they are still at risk of experiencing any form of abuse. The next sections were divided into the sections: cultural beliefs about DVA, who the abusers can be, the cycle of abuse, risk factors that lead to DV and early awareness of it, promoting protective influences that can help in the prevention of DV, laws of DV in the U.S. including the victim's right to protective orders, helpful national and local resources for DV victims, psychoeducation on the various DV effects on victims and their family members, and the different types of interventions and professionals,, whether legal or mental health professionals, that victims can seek to start their legal journey or treatment journey.

The introduction to the definition of domestic violence and its different forms section included a definition of DV and each form of DV, and it aimed to help consumers to identify if they have been victims of any form of DV in their lifetime and aid mental health providers in providing psychoeducation to women who might be more prone to experiencing DV about what it can look like. This section aimed to show the severity of DV as a public health and mental health problem that is preventable if help is sought.

The cultural risk factors and reinforcing elements for the continuation of the cycle of abuse and the prevalence of domestic violence section discussed the cultural values, societal norms, and gender roles that were ingrained in Arab women's minds, contributing to the normalization and experience of DV. This section included the most common cultural beliefs and values, along with Arab societal norms of family honor being tied to women, DV being a private matter, and family cohesion over women's well-being and safety.

Another section covered risk factors that lead to DV among Arab women for early identification of DV behaviors and the protective factors that can help in the prevention of DV. That section aimed to help women in the early identification of DV acts and prevent further

exposure to DV. The section also included the laws of DV in the U.S., such as the victim's right to protective orders, supportive national and local resources for DV victims, and psychoeducation on how DV impacts victims and their family members.

The last and largest section discussed the different types of interventions and professionals, whether legal or mental health professionals, that victims can seek for help in case of witnessing or experiencing domestic violence. This section aims to provide Arab American women with the appropriate services and culturally sensitive interventions for IPV. It also included step-by-step explanations of how DV victims and survivors can access different websites, such as their counties' mental health departments' websites, to reach out to mental health providers in their native language or similar cultural background. This section also aimed to normalize the seeking and receiving of mental health services and challenge the negative perceptions surrounding these services, specifically around the serious DV issue among Arab American women.

This product was entirely reviewed by clinical psychologists and licensed therapists in the field who have worked or are currently working with the focus population of the study as well as the dissertation chair and committee members. Reviewers of psychologists, licensed therapists, and dissertation chair and committee members will provide feedback and recommendations that will be integrated into the development of more culturally appropriate IPV intervention approaches to include in this booklet.

Product Review

The Domestic Violence Among Arab Women and Immigrant Arab Women Prevention Manual was distributed to mental health professionals to review and provide feedback on its effectiveness and relevance in working with the target population. The inclusion criteria for

mental health professionals' eligibility to review the manual included coming either from a Middle Eastern background or having worked with the Arab population to ensure their understanding of the target population risk factors and their familiarity with the cultural beliefs, traditions, and practices contributing to the prevalence of the DV issue. Psychologists and other mental health professionals within different mental health settings were approached to assess their clinical experience relevance and their willingness to engage in the process of review and evaluation of the psychoeducational manual as a part of the dissertation project in fulfillment of a PsyD degree.

Five psychologists agreed to review the psychoeducational manual, including three psychologists, two of whom are clinical psychologists, and one is an industrial/organizational psychologist. The other two reviewers held marriage and family therapy (MFT) degrees, and one clinician also had a doctorate in MFT. The psychoeducational manual reviewers are as follows: Dr. Beyou Tsegaye, a licensed clinical psychologist who has been practicing in the mental health field for 40 years with more than 20 years of experience with the Arab American population, Dr. George Gharibian, a licensed clinical psychologist and associate professor with 19 years of experience in the mental health field and 10 years of experience with the Arab American population; Dr. Maher Sonbol, an industrial/organizational psychologist and licensed marriage and family therapist; Dr. Clara Bertan, a licensed marriage and family therapist and doctor of marriage and family therapy with 15 years of experience in couples and family therapy, and Ms. Julia Gunderson, a licensed marriage and family therapy with years of experience in community mental health serving diverse underserved individuals and families.

Organization and Clarity. Four reviewers (80%) have rated the clarity and organization of the manual's content as excellent, while one reviewer has rated it as good (20%).

Two reviewers (40%) reported that the most helpful sections in informing their clinical work with the focus population of the manual were the interventions sections, while one reviewer (20%) reported the practical recommendations section to be the most helpful in informing their clinical work. Two reviewers (40%) reported the Arab women demographics, risk factors perpetuating DV, and acculturation among Arab Americans sections to be the most helpful in informing clinicians' work with the target population.

Areas in need of Improvement. Regarding the sections that are in need of improvement, one reviewer (20%) reported that all sections are covered properly, another reviewer (20%) answered the prevalence section to need further region-specific data to demonstrate the severity of the DV issue in the Arab world, and two reviewers (40%) answered the DV supportive resources section to be in need of expansion and improvement in future editions of the manual. Another reviewer (20%) answered that the appendix section needs improvement, suggesting the addition of culturally adapted IPV screening measures to assess clients' safety.

Relevance of Topics. For the relevance of the topics covered in the manual, four reviewers rated the topics covered to be very relevant (80%), while another reviewer rated them to be somewhat relevant (20%). Five reviewers (100%) agreed that the strategies and interventions outlined in the manual are applicable when working with Arab women experiencing DV. The reviewers also answered a question about the relevant DV considerations and factors that mental health professionals would benefit from learning when working with the focus population of Arab women. One reviewer suggested utilizing community leaders and volunteers as mediators to aid in connecting with clients, as well as discussing the attribution model of mental health with them in order to explore clients' perspectives and thoughts about seeking mental health services. Another consideration, the same reviewer emphasized, was

collaborating and training physicians in screening for DV and referring clients in need to mental health clinicians and resources. Another reviewer recommended adding a translated section of DV to make the manual a more useful and direct tool for clinicians in the field to utilize and make accessible for clients of Arab American women who have English as their second language, along with including case studies or vignettes to provide clinicians with practical application of the content and prompt deeper reflection in training settings. A different reviewer offered another consideration, emphasizing the need for an increased awareness about the influence of religious values and faith leaders on both perpetuating and mitigating Arab women's experiences of DV to ensure the utilization of both culturally congruent and clinically effective treatment interventions. Another suggested consideration for clinicians working with the focus population was offered by a different reviewer: assessing for the history of trauma and any psychological issues, as well as accounting for acculturation level differences. Incorporating specific recommendations for community and faith-based resources was another recommendation by one of the reviewers, highlighting the leverage of trusted religious leaders and community advocates in interventions and programs supporting DV victims of women.

Manual effectiveness. In rating the psychoeducational manual's effectiveness, four reviewers (80%) rated the manual to be very effective, while one reviewer (20%) rated it to be somewhat effective in assisting Arab women with DV experiences in treatment. Regarding the manual's usability and accessibility, one reviewer rated it as very user-friendly (20%), three reviewers rated it as somewhat user-friendly (60%), and one other reviewer (20%) rated it as not very user-friendly due to its dissertation-like style, making its readability an area to be improved on to make the manual a more user-friendly and effective tool.

Suggestions for improvement. For the suggestions for the improvement and enhancing the usability or effectiveness of the manual, one reviewer suggested (1) more professional formatting and design to create a visually accessible layout to enhance the manual's usability, particularly for busy clinicians; (2) creating a training companion guide as a brief facilitator's guide to help clinicians run DV workshops; and (3) adding an appendix with tools including sample intake forms, safety planning templates, and culturally adapted screening tools for IPV. Another reviewer suggested adding bullet points and numbered lists to highlight key information of each manual section to ease and inform clinicians' work with the target population. Another reviewer suggested discussing more research on the perpetrators' interventions and treatment programs, as well as contributing factors to their beliefs about women and DV, which results in the prevalence of the abuse amongst the target population. Two reviewers suggested a more robust DV supportive resources section to offer a wide variety of accessible resources to women with different levels of acculturation and needs along with the expansion of clinical tools and culturally adapted intervention scripts, including (1) expanding on the religious/spiritual content to explore the impact of their interpretations of DV rates; (2) providing a stronger resource appendix with multilingual tools; (3) adding client vignettes with varying levels of acculturation and DV experiences to support contextual understanding; and (4) providing a section on male domestic violence victims to address unique cultural barriers they also face in seeking help that are similar to or different from the barriers faced by Arab women victims of DV. The reviewers also rated their overall satisfaction with the manual, in which three reviewers reported being very satisfied (60%) and one reviewer reported being somewhat satisfied (20%), highlighting the need for clinical tools and visual aids, and one reviewer reported being not very satisfied (50%), emphasizing that the manual entailed great content yet

had a literature review format, possibly decreasing the clinicians' likelihood of engaging with its material. The same reviewer suggested a more concise and practical format for mental health professionals to maximize their benefit from the manual as a psychoeducational tool in treatment with the target population.

Additional Information Lastly, the additional comments section offered the reviewers the opportunity to share any additional thoughts, comments, and concerns about the manual or its relevance and accessibility. In this section, one reviewer kindly described the manual as a comprehensive and culturally sensitive tool that integrates a strong theoretical foundation with practical recommendations and insight into the experiences of Arab women experiencing DV, while another reviewer shared that the manual is an inclusive tool that provides a comprehensive perspective on DVA among Arab American women and raises awareness on this topic to help in supporting victims of DV as well as reducing the prevalence of the issue among the focus population of the manual. Two other reviewers iterated a similar comment, recognizing the academically rigorous and rich nature of the manual being a part of the dissertation project while emphasizing the need for a practical and more user-friendly format to enhance its accessibility for busy practitioners seeking immediate application in therapeutic settings, with the suggestion of adding recommended resources and tools sections in Arabic to ease Arab women immigrants' accessibility to supportive resources. This recommendation was not integrated into the manual, as it extended beyond the normal scope of a psychoeducational dissertation product to include infographic or fact sheet work. The incorporation of such suggestions would require collaboration with multiple professionals, such as graphic designers for visual materials and interpreters for developing sections in Arabic utilizing culturally sensitive language.

It was decided to format the manual in a literature review-like format due to certain guidelines that it has to follow as a part of the dissertation project, which needs to meet all the guideline requirements in fulfillment of graduation requirements. However, the reviewers' comments were very valuable and practical in that they will be considered and included in future editions of the manual if it were to be published to enhance its usability and accessibility.

The process of gathering and incorporating the manual reviewers' feedback has been an invaluable part of the dissertation product development process. Receiving the reviewers' evaluations and feedback was insightful and informative in not only addressing the areas that would benefit from improvement but also acknowledging strong areas in which sections comprehensively captured the target population's multi-layered identities and factors contributing to the DV issue. The reviewers' feedback has also emphasized the significance of cultural competency in working with the target population, as each reviewer has provided invaluable feedback on strength areas and areas of growth from their own cultural lens and unique perspective formed by their non-clinical interactions and clinical work with the identified population of Arab American women. Their thorough and targeted feedback was appreciated and valuable in informing future directions of the manual to develop into a more practical and accessible tool for busy clinicians. Their evaluations were encouraging and constructive, which would strongly support the process of creating a more practical and accessible manual that offers comprehensive tools and culturally sensitive resources for clinicians to utilize with Arab women victims of DV.

Chapter IV

Discussion

Conclusions

Domestic violence represents a breach of fundamental human rights cutting across the lines of gender, ethnic backgrounds, religious identities, and SES levels. While DV is a pervasive issue among women across the world, it is a particularly significant area of concern for Arab American women, whose social norms and cultural factors contribute to higher rates of violence and abuse, all while they navigate adjusting to a new host culture.

The patriarchal society and beliefs of the Arab culture not only contribute to difficulties in the process for Arab American immigrants but also to the continuous stigma and shame associated with speaking up about DVA experiences. As the patriarchal system and male guardianship customs continue to impact women's rights in many societies today, the normalization of violence against women continues and impacts the lives of not only women but also their families, who attempt to preserve their reputation and family bonds beyond the abuse. Based on the discussed research, higher rates of DV violence remain higher among Arab women due to some of the societal norms, gender roles, sociopolitical conditions, and cultural traditions that reinforce the cycle of violence and provide perpetrators with lenient policies and laws decriminalizing the abuse against women. Therefore, the consideration of these systemic barriers is crucial in training culturally competent clinicians who recognize Arab women's unique backgrounds.

Clinicians and practitioners must consider multicultural guidelines when working with the target population of Arab women by reflecting on their own cultural biases in combination with educating themselves about culturally sensitive interventions to avoid imposing Western

approaches on women of color and better understand Arab women's cultural contexts. Providing minoritized populations, including Arab women, with culturally sensitive treatment also entails the use of non-stigmatizing language, followed by using certain Arab terms or translated resources offered to the clinicians in future editions of the manual. Practitioners must also recognize Arab women who have intersecting minoritized identities and acknowledge how these identities shape their lived experiences of DV.

Implications for Practice in a Multicultural Society

Addressing the issue of DV with Arab American women must be approached through culturally sensitive and responsive interventions by culturally competent clinicians who are educated or who have done sufficient research to learn about the multiple intersecting identities, cultural factors, socioeconomic and educational statuses, and acculturation levels contributing to varied DV experiences lived by diverse Arab immigrant women. Clinicians acknowledging Arab women's varied DV experiences and various intersecting identities, including language, religious background, faith community engagement, immigration status, and acculturation levels, aid in understanding the intricacies of their DV experiences and the underlying causes contributing to the continuation of the cycle of abuse. First, clinicians engaging in research to gain information and insight into other cultures, their customs, and traditions that impact individuals' personalities and values would support their cultural self-reflection and would inform their choice of evidence-based frameworks that honor the collectivistic nature of the majority of Arab cultures, stigma surrounding mental health and seeking its services. The clinician working with the Arab population must come to the self-awareness level of not only recognizing the clients' cultural values but also offering respect and acknowledgement of how these values contributed to previous or current experiences of violence and abuse. Through understanding the Arab cultural

values, the role of immigration, and acculturation levels, practitioners can integrate cultural responsiveness and humility into their intervention strategies for delivering culturally sensitive treatment.

Strengths and Limitations

The reviewers provided their insight on some of the psychoeducational manual's strengths, emphasizing its academically rigorous and culturally sensitive sections, which reportedly offered thoughtful integration of sociopolitical, acculturation, and psychological perspectives about the issue of DV among Arab American women. Another reported strength was the practical recommendations that the psychoeducational manual provides, which give insight into the distinct experiences of Arab women experiencing DV as well as how to tailor existing DV treatment approaches to the unique issues and needs of Arab American women. Developing a psychoeducational manual on DV among Arab women entails some strengths, as it sheds light on an understudied and prevalent issue threatening the lives of thousands of Arab women and silencing their voices. One of its strengths resides in acknowledging the risk factors contributing to the higher prevalence rates of DV and the vulnerabilities of the Arab women population to educate and train culturally competent clinicians who can identify and address the factors contributing to the abuse issue in treatment with their clients. The psychoeducational nature of the manual would also provide DV victims with the definitions and distinctions between the different forms of violence and their prevalence rates worldwide to reduce feelings of isolation and shame surrounding their DV experiences. Another strength of the psychoeducational manual that can contribute to improving clinical work with DV victims of Arab women is recognizing and honoring the Arab traditions and values through providing culturally sensitive interventions and appropriate resources that Arab women would feel safe

accessing. Similar to any clinical tool, the psychoeducational manual has limitations, which varied among reviewers, with some reviewers reporting a limitation being the lack of an integrated anonymized case studies or vignettes section in the manual, describing it as a deprivation of practical applications of the manual's content to the clinicians, resulting in missing opportunities for deeper reflection on the cultural context of DV in training settings. Another limitation lies in the lack of resources to provide interpreted sections in Arabic, particularly on DV definitions and prevalence rates, and the resources list, along with a section on the Arabic terminology to utilize with DV victims to help destigmatize speaking up about their DV experiences and normalize seeking mental health services. The main limitation and consideration that clinicians need to be aware of when utilizing this psychoeducational manual is that it does not capture the full diversity of Arab statistics, risk factors, values, customs, and traditions. Particularly, it does not provide an extensive literature review on the various aspects and identities contributing to the prevalence of DV in Arab societies, including religion, sociopolitical factors, SES background, immigration statuses, and migration history. Also, due to the psychoeducational manual topic being an understudied area, the regional DV prevalence data of the Arab world are limited and not the most up-to-date, not only due to the scarcity of recent research on the subject but also due to the possible underreporting of DV experiences within existing published data.

Future Directions

The discussion on the future development of this psychoeducational manual starts with considerations that would enhance work with the target population in the area of DV interventions and treatment programs developed to consider the vulnerabilities and meet the unique needs of Arab American women. Therefore, future directions would focus on collecting

and incorporating community-based case studies and vignettes to further investigate the common risk and protective factors leading to DVA among Arab American women. One crucial future direction of the manual is to normalize speaking up about DV experiences and increase access to culturally sensitive mental health services through collaboration with community religious leaders and organizations within the Arab communities that support the cause of empowering women and raising awareness about DV. Future editions of the psychoeducational manual would need to expand more on the intersectionality of Arab women's identities as well as the intersectionality of the DVA issues with concurrent issues such as acculturation stress, immigration/refugee statuses, and mental health stigma.

The discussion on DVA and abuse is a deeply personal one for countless Arab women, particularly those who grew up aligning with the Arab society's values of the patriarchal system and the collective identity of the Arab cultural values, leading women to prioritize the cohesiveness of a family over their safety and well-being. Therefore, it is crucial for clinicians serving that population to remember the unique background and individual experiences that shaped the DV victims' lives to approach them from a place of curiosity, humility, and compassion to support them on their healing journeys. The role of a clinician working with Arab women is not only to destigmatize mental health and provide culturally sensitive interventions, but it is also to be a witness to the women victims' silenced experiences, resiliency, and patience that have led them to survive abusive relationships and family situations. Besides being educators on the DV types, the risk factors, and prevalence rates, clinicians operate as supporters, listeners, believers, and guides who empower women through holding non-judgmental spaces and unconditional positive regard rooted not only in evidence-based practice but also in offering genuine and authentic care and cultural awareness that become as powerful as all therapeutic

interventions can be in making clients feel seen, heard, and most importantly, empowered.

Suggestions for Future Research

This psychoeducational manual opens the window for future research on the prevalence of the DV issue and its risk factors among the population of Arab women. It also provides the initial steps for future researchers to address DVA in culturally sensitive ways as a means for early prevention of DV among Arab populations of both men and women. The nature of the resource may differ between further studies on the issue, handbooks, or similar psychoeducational manuals, depending on the target audience and other factors; however, suggestions for future research may include the unification of content across all resources with sections that address the enabling cultural beliefs and practices resulting in the prevalence of the DV issue to raise awareness among Arab populations. Future researchers may also consider emphasizing some pre-existing or newly developed preventative methods to not only help in challenging the harmful beliefs and gender norms contributing to the ongoing cycle of abuse but also to support radical behavioral change in both men and women within Arab communities. This may be achievable through the inclusion of case vignettes of the unique experiences encountered by DV victims of Arab women to address the values, cultural barriers, family dynamics, and any community involvement that may have hindered their ability to seek or access supportive services following the violence and abuse. Given that this current psychoeducational manual solely emphasizes the empowerment and treatment of victims of DV, future adaptations of it may benefit from providing outlines of practical steps of change for perpetrators of violence that can be discussed in psychoeducational settings, whether group, family, or other therapeutic settings. In Bancroft (2002), the steps to change for male perpetrators of violence are discussed as mandatory to make lasting behavioral changes and support the perpetrators of violence

through the process of taking accountability for their actions. Some of the mandatory steps to change that are emphasized include acknowledging that their behavior is a choice, quitting the blame of the victim, recognizing the impact of their abuse, developing respectful behaviors to replace the abuse, and making amends for the damage inflicted on the victims and any involved parties (Brancroft, 2002). This is a brief outline that can be expanded upon during the psychoeducational phase of treatment, in which it would serve as both a preventative measure and a necessary step in challenging the patriarchal and cultural beliefs directly contributing to the normalization and acceptance of violence by Arab men. The psychoeducational manual's focus is on the cultural and risk factors sections contributing to DV, along with integrating perpetrator-focused interventions into the treatment process, which would promote behavioral change and reduce recidivism while also raising awareness of the severe consequences of violence and abuse on the overall mental and bodily health of women, the development of children, and overall family dynamics.

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APPENDIX A

Domestic Violence Prevalence Rates, Effects, and Risk Factors Among Arab Women: A Psychoeducational Manual

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Introduction/Purpose of the Manual

This psychoeducational manual aims to serve as a comprehensive resource for mental health professionals in different community organizations working to combat domestic violence and foster awareness and resilience among the Arab American population. The manual includes evidence-based approaches and cultural considerations to appropriately address the unique barriers and advocate practical tools for intervention and preventative and recovery measures for the Arab American population of women. By utilizing current research on domestic violence and identifying culturally sensitive practices for violence and abuse among minoritized women, this manual seeks to educate and empower mental health professionals with the knowledge and skills necessary to effectively address domestic violence in various contexts while working with women of Arab descent. Women undergo a range of DVA experiences across different stages of their lifetime. These abuse experiences are not always disclosed to family or friends nor reported to law enforcement, leaving women at risk of further exposure to such abuse. Hopefully, the ability to recognize and potentially address this issue could assist women and their families in achieving a better quality of life.

What is included in the psychoeducational manual?

The information presented in this psychoeducation manual aims to help mental health practitioners with a comprehensive literature review and culturally sensitive interventions for domestic violence and abuse as it prevails among the population of Arab American and immigrant Arab women. The manual explores some of the most prevalent types of DV experienced by Arab women from diverse backgrounds and marital statuses. This psychoeducational manual is also organized into the following sections to provide practical guidance on addressing domestic violence among Arab American women: Domestic Violence

(DV) definition and Worldwide Prevalence Rates, Arab women demographics and DV, acculturation among Arab Americans, cultural norms and beliefs impacting, acculturation among Arab Americans, global interventions utilized with DV victims of women, interventions with DV victims of Arab American women.

Domestic Violence (DV) Definition and Worldwide Prevalence Rates

Dokkedahl et al. (2019) describe DV as a range of behaviors within intimate partnerships intended to inflict physical, psychological, or sexual harm (Dokkedahl et al., 2019). The WHO describes DV as a form of gender-based abuse targeted towards women, comprising physical, emotional, and sexual abuse and other dominating acts perpetrated by a partner or family member (WHO, 2012, p. 1). Domestic violence also encompasses the practice of female genital mutilation, trafficking of women, and honor killings (Garcia-Moreno et al., 2013). The term 'battered women' is used to broach the action of battering experienced by women as a severe form of DV that is characterized by various manifestations of physical violence, threats, coercion, and dominance and controlling behaviors done by the abuser toward their victim (WHO, 2012).

Domestic Violence (DV) is one of the most prevalent issues that is still experienced by women in our society. Domestic violence remains one of the primary contributors to injuries among women. Globally, it is estimated that 30% of women encounter domestic and intimate partner violence at some stage in their lives, and about 25.7% of women's visits to the emergency room are connected to their exposure to incidents of domestic violence (WHO, 2021). Globally, it is estimated by the WHO (2013) that 38% of all homicide cases involving women are perpetrated by previous or current male partners. Intimate Partner Violence (IPV), a subtype of DV, not only has drastic negative consequences on women's health, both mental and

physical, but it also negatively affects their sexual and reproductive health. Domestic violence has several forms besides physical abuse and battering, including emotional, sexual, psychological, and economic abuse. Women worldwide have been victims of DV for decades, as they have been seen as physically, emotionally, and intellectually inferior to men in many societies (Elghossain et al., 2019).

DV Prevalence and Effects

Domestic violence and abuse have become so normalized that even though they are widespread, the issue remains invisible in many societies (Niaz et al., 2017). Domestic violence, or IPV, is a worldwide issue that concerns both public health and human rights and has dire, persistent impacts on women's overall well-being, both physical and emotional. Although physical and psychological violence types of DV are estimated to be the most prevalent DV forms, domestic violence includes a broader array of behaviors and forms intended to cause harm to the victims. Existing research also suggests that different forms of DV or IPV often coexist; thus, physical IPV is often accompanied by both emotional and sexual IPV (World Health Organization, 2012). As outlined in the WHO (2021) fact sheet, the lifetime incidence of IPV targeting women is estimated at 20% in the Western Pacific and 22% in Europe and higher-income nations, 25% in parts of the Americas, and escalates further to 31% in the WHO Eastern Mediterranean regions and 33% in both the African and Southeast Asian regions recognized by the WHO. The Arab world falls in the Mediterranean region, which holds the second-highest rate of DV worldwide. Similarly, Arab American women experience DV at higher rates compared to worldwide average DV rates, primarily due to various sociocultural factors, including patriarchal family systems and deeply rooted cultural norms and traditions (Mojahed et al., 2020).

Domestic abuse and violence result in many significant health issues, leaving women victims suffering from injuries, persistent pain, migraines, sleep disorders, pelvic pain, and digestive issues (Khadra et al., 2014). As indicated by the Centers for Disease Control and Prevention (CDC), which obtained statistics from the National Intimate Partner and Sexual Violence Survey (NISVS), it is estimated that $5.8 billion is spent on medical and mental health costs that result from IPV annually in the U.S. (CDC, 2014). The NISVS survey also indicated that Black and multiracial women and immigrant women exhibit higher lifetime prevalence rates of physical violence than White-identified women (CDC, 2014). Women who had experienced any form of abuse have been found to express higher levels of fear, anger, and overall psychological distress than non-abused women (Haj-Yahia, 1999). The negative effects of Domestic Violence and Abuse (DVA) extend beyond physical and physiological consequences to also include profound mental health symptoms, including depressive symptoms, anxiety-related signs, PTSD, somatization, and suicidal tendencies (Khadra et al., 2014). Women who experienced severe forms of DVA have also been found to exhibit symptoms of PTSD, frequently manifested as recurring nightmares, involuntary memories of the abusive incidents, steering away from recalling the abusive incidents, and heightened arousal states (Khadra et al., 2014).

Global data suggest that one-third of women (30%) have suffered either sexual or physical abuse by a romantic partner or a relative throughout their lives, according to the analysis of DV prevalence rates across 161 countries (WHO, 2021). It is estimated that 8% of global murders of women are perpetrated by their intimate partners, while 42% of women with past experiences of IPV indicate sustaining the physical injuries as a consequence of such violence (WHO, 2021). In 2022, as indicated on the National Coalition Against Domestic Violence's (NCADV) statistics fact sheet, one out of every three American women endured a level of DV

from a partner, while one in every seven American women has been injured by a romantic partner. Rape is a subtype of sexual DV that remains prevalent worldwide. It is estimated that one out of every 10 American women has been raped by a partner (NCADV, 2022). Nationwide, DV hotlines receive approximately 20,000 phone calls on a typical day, reporting some form of DV (NCADV, 2022).

In a study by Sardinha et al. (2022), global estimates were developed for the prevalence of DVA targeted towards women. The study reviewed data collected from the WHO Global Database of 366 eligible studies, which included responses from two million women in 161 countries regarding their experiences with IPV. The study found that an estimated 27% of participating women in the 15-to-49-year age range suffered physical violence, sexual abuse, or both perpetuated by a romantic partner. Furthermore, DV experiences are intertwined with child abuse incidents, with 24% of adolescent girls and young women aged 15 to 19 years reporting experiencing DV at least once since the age of 15 (Sardinha et al., 2022). This finding indicates that 16%, or one in six women aged 15 to 24 years, have encountered physical or sexual abuse or both within the year before the study (Sardinha et al. 2022). Such findings underscore significant concerns for young women's bodily and mental wellness, given the lasting health impact of violence on their overall growth and health. These prevalence rates are higher for lifetime IPV among women in low-income countries compared with higher-income countries (Sardinha et al. 2022), a disparity that can be attributed to factors such as resource scarcity, cultural norms, low literacy and awareness, and inadequate legal protection for victims of IPV. However, many of the national and global reports have a primary focus on the higher incidence rates of IPV in the manifestations of physical and sexual abuse, often overlooking the experiences of women

subjected to other forms of violence, encompassing threats/intimidation, emotional abuse, and financial abuse.

The variations in definitions and measurements of psychological and emotional abuse against women have contributed to the exclusion of these forms of abuse from global reports and studies assessing the prevalence rates of IPV (WHO, 2013). Furthermore, this limitation extends to overshadowing other forms of abuse that are more prevalent among minority women, such as threats, intimidation, and financial abuse, which remain higher among the focus population of the manual due to traditions and cultural norms restricting women's autonomy opportunities. The acts of emotional abuse take different forms, including threats of violence, humiliation, enforcement of social isolation, and withholding of financial resources (Jewkes, 2010). Differences in cultural and individual perceptions of abuse also contribute to the rates of reporting and the impact that emotional abuse leaves. These limitations confirm the need for the inclusion of psychological and emotional abuse in DV screenings to establish a comprehensive foundation for reporting and data collection on such types of violence against women. This inclusion would also facilitate more accurate monitoring of the regional and global prevalence rates of DV. The improved estimates of IPV prevalence are essential in shaping the responsive prevention and effective intervention efforts and programs. As the results of the WHO (2021) fact sheet reveal, this study's focus population of Arab women falls in the Mediterranean region, which has the world's second-highest prevalence rates of IPV. These findings reveal the seriousness of DV as a major issue affecting public health and breaching the fundamental human rights of Arab women (Mojahed et al., 2020). These findings also call for more comprehensive research and intervention development studies to aid in the early intervention and prevention of DV among Arab women. Having a thorough understanding of domestic violence, its types, and

its prevalence rates worldwide is essential in moving the focus to examine the domestic violence issue within the manual target population of Arab women, as their unique demographics and statistical realities fluctuate the prevalence of the issue across Arab societies.

Domestic violence is an infringement on women's fundamental rights globally, and it is more prevalent among Arab women due to cultural beliefs and societal factors, with sexual and physical abuse as the more common forms of it. While emotional, psychological, and financial abuse are often overlooked, this highlights the need for comprehensive screening and prevention measures. Therefore, effective addressing of the DV issue begins with the implementation of culturally supportive services to offer services tailored to the needs of minoritized women who are victims and survivors of DV. The next section aims to offer insight into the prevalence rates of DV in Arab societies and discuss the demographics of Arab women who constitute those statistics.

Arab Women Demographics and DV Statistics

The Arab world today, as we know it, consists of 22 countries with a population of 464 million people as of 2020. According to the World Bank Data from 2020, Arab women comprise almost half of that population, with about 223 million women (48.2%). About 30% of women worldwide report encountering a form of violence perpetrated by their partner or family member (Heywood, 2019). Domestic violence and abuse have been normalized and overlooked phenomena that, when widespread, became invisible crimes that are ingrained within cultural norms in many societies (Niaz et al., 2017). Across the Mediterranean countries, the rate of women reporting encounters with some form of DV is higher than the world average at 37%, along with indicators that the on-ground percentage might be higher (El-Nimr et al., 2021). Women in the 22 Arab countries have been restricted by religion, culture, and traditions from achieving equal rights

compared to men. For decades, Arab women have been fighting for gender parity in most situations, including education, politics, and the workforce. Similar to many women around the world, Arab women have been taught not to discuss DV due to the conservative cultural traditions and the shame associated with the abuse. The tolerance of DV and the rationalizations given to partners or parents who commit these acts against women are mainly due to society's belief in male authority over female family members (Haj-Yahia, 1998). Since male dominance over women in the Arab world is a pervasive belief, the fight against this traditional belief is crucial to witness and encounter real change and action toward DVA laws and their victims of Arab women.

Surveys conducted in certain Arab countries such as Egypt, Palestine, and Tunisia, surveys reveal that approximately one out of every three women has encountered instances of physical IPV (Douki et al., 2003). In the 1996 Egyptian Demographic and Health Survey, which included a study group of 14,779 individuals, it was found that one in three married Egyptian women were physically abused at least once during their marriage, with one-third of these women also being subjected to physical violence during their pregnancies (El-Zanaty et al., 1996). In 2005, the Demographic and Health Survey of Egypt found IPV prevalence rates as high as 47% among women, with previous or current husbands being the most commonly reported perpetrators (El-Zanaty & Way, 2006). The survey also found that nearly half of the previously or currently married women aged 15 to 49 reported instances of physical abuse against them, including getting hit or slapped at some point after age fifteen (El-Zanaty & Way, 2006).

Another important finding in the Demographic and Health Survey of Egypt was the strong correlation between women's marital status and the likelihood of ever experiencing DV in their lifetime with 75% of the reported divorced or separated women encountering at least one DV experience in comparison to 43% of currently widowed women and 45% of currently married

women (El-Zanaty & Way, 2006). In another study by Belhaj et al. (1998), a survey conducted with 500 Tunisian women found that 33.8% of women shared experiencing physical abuse from their husbands or other male family members at least once in their lifetime (Haj Yahia, 2001). In Medina, Saudi Arabia, 689 married and previously married women participated in interviews conducted by primary health care centers, answering a questionnaire that incorporated components from three different measures: the Modified Conflict Tactic Scale, the Kansas Marital Scale, and the Lie Scale of the Minnesota Multiphase Personality Inventory. The questionnaire aimed to assess the frequency and forms of DVA experienced by Saudi women. Among the 68 women participants, it was discovered that 25.7% of respondents experienced physical violence, while 32.8% reported encountering psychological abuse in the absence of physical violence (Al-Tashkandi, 2009). Of the percentage that reported physical abuse, 36.7% of women reported suffering from minor DV incidents, while 63.3% reported experiencing severe physical abuse incidents. Arab women exhibited a lifetime prevalence of DV at 57.7%, a significantly higher rate compared to DV rates among women worldwide (Al-Tashkandi, 2009). The same study found that only 36.7% of 109 abused women had disclosed their physical abuse experiences with their primary care physician, indicating the shame surrounding the disclosure of DV or seeking professional help. This study demonstrates how DV is still not treated as a severe, prevalent problem and a crime against Arab women in that region of the world. The lower rates of DV reporting among Arab women can be indicative of various factors, including a perceived lack of safety in disclosing DV to professionals, adherence to cultural traditions regarding the importance of family preservation, and the aim to protect the family's reputation and avoid any stigma by refraining from speaking up about DV or seeking divorce. Furthermore, research findings in the

Arab region continue to illuminate the internalized stigma among women, preventing them from disclosing their own abuse experiences due to the blame and shame associated with it.

Arab Traditions and Culture

The normalizing of DV and the lenient laws decriminalizing DV perpetrators, particularly in the Arab world, are direct results of the society's belief in male supremacy over female family members (Haj-Yahia, 1998). Domestic violence concerns the harmful acts and abuse inflicted by an intimate partner or family relatives against their victim. As defined by the National Coalition Against Domestic Violence (NCADV), forms of DV include any abusive behavior that is exhibited to dominate and exert power over the other in many ways besides physical abuse, such as sexual, emotional, financial, and psychological abusive behaviors. Although intact evidence and a database of IPV against Arab women do not exist, previous and current studies have found substantial levels of IPV, including psychological, physical, and sexual violence against Arab women in many settings (Elghossian, 2019). Domestic violence definitions remain the same in the Arab world, and its manifestations resemble those experienced by women worldwide. The main difference lies in how some DV forms, such as financial abuse, are more prevalent within Arab countries compared to other regions around the world. However, the traditions and cultural norms dictate Arab women's behaviors to a great extent, as women are seen as the ones that bring shame to their families in many ways, including challenging men's authority, dressing immodestly, separating from their husbands, asking for a divorce, and any other activity that might be perceived as belittling the honor of the family, as women are seen as the honor of the family in that part of the world (Abu-Ras, 2007).

Domestic violence can manifest as a single incident or repeated acts of abuse, presenting in multiple ways, such as physical, psychological, emotional, sexual, and financial harm,

alongside controlling behaviors. The violence experienced by women only is classified as gender-based violence, and just like DV, García-Moreno et al. (2013) identified the varying manifestations of gendered violence, such as IPV, harmful practices like female genital mutilation, and sexual abuse by non-partners. The pervasiveness of the DVA types experienced by women worldwide varies, and it is common for women to encounter more than one form of DVA throughout their lives. Unfortunately, many of these gender-based forms of violence are still practiced today despite their barbaric nature, such as genital mutilation, which is not banned in most Arab countries except for Iraq and Oman, according to Equality Now (2024). Sexual violence, or rape, constitutes a form of IPV that not only occurs at higher rates in Arab countries but is augmented by lenient laws across the Arab region to the extent that they can avoid prosecution by marrying their victims. According to UN Women, Morocco is the only Arab country that has repealed these laws after a rape victim decided to end her life due to being forced to marry her rapist.

The higher rates of DV incidents among Arab women can be due to different factors as discussed in this section, varying from cultural, societal, familial, religious, or even the individual factors of the woman being exposed to this type of abuse. The underreporting of DV incidents was also tied to these factors, which directly impact the safety of the victims and survivors of women who attempt to report their DV experiences despite the stigma and shame associated with speaking up against their perpetrators of family members or partners. The same factors leading to the underreporting of DV incidents were also tied to the normalizing of DV among Arab women and the passing of lenient laws for DV perpetrators in that region of the world. This section also discusses the different forms of DV and the prevalence rates of DV types among Arab women, and it emphasizes how financial abuse prevalence rates in that region

remain higher than worldwide prevalence rates due to the traditions and cultural norms that restrict women's behaviors, including seeking similar educational and occupational opportunities as men. Despite financial abuse being a more prevalent form of abuse among Arab women compared to women in the Western world, emotional abuse was identified as the predominant form of abuse encountered by Arab women, which is consistent with the worldwide prevalence rates. Arab cultural norms and traditions have an undeniable influence on women's willingness to report DV and openly discuss their DV experiences. However, the lack of robust laws protecting women's rights from their perpetrators in this region of the world exacerbates the stigma around speaking out about DV and increases the victimization of women. The impact of the discussed risk factors on the reactions and behaviors of abused women towards DV is still being explored, and it explains why women may choose to refrain from seeking professional help or leaving their abusers. There is a need to further examine the risk factors.

The normalization of abuse and gender-based violence, underreporting of DV incidents due to stigma and societal pressure, and inadequate legal protections contribute to the sustained victimization of women across Arab countries. Although awareness about DV as a human rights breach is growing, DVA remains a serious public health problem, characterized by physical, emotional, psychological, and financial control and abuse disproportionately affecting Arab women. Male authority and family honor, reinforced by cultural norms, continue to limit women's ability to report or escape abusive relationships and situations. Addressing these challenges and challenging societal norms requires a multifaceted approach involving legal reform, increased societal awareness, and improved support systems. The key factors in monitoring DV statistics among Arab women rely on having a comprehensive understanding of the risk factors perpetuating DV in Arab societies. Identifying the risk factors contributing to DV

targeting Arab women is crucial in the empowerment and psychoeducation of women on the factors leading to the prevalence of specific forms of DV among them, as presented in the next section.

Risk Factors Perpetuating DV Among Arab Women

Domestic violence is recognized as a critical human rights concern breaching Arab women's fundamental rights and is supported by cultural taboos and some conservative religious beliefs (Wali et al., 2020). Arab women continue to encounter obstacles in receiving equal access to education, social opportunities, economic opportunities, and political representation in most Arab countries (Elghossain et al., 2019). Identifying the risk factors for DVA can be challenging as a result of the several social barriers and conflicts facing DV victims of women, hindering their ability to seek support or break away from their abusers (Fugate et al., 2005). The social barriers vary between shame surrounding the issue of domestic violence and the other barriers that come with speaking about it, such as criticism for staying or leaving, fear for one's life, and mistrust of the help source (Vranda et al. 2018). The research by Mojahed et al. (2020) classified the various DV risk factors into four categories following the ecological model. The four risk factor levels included the individual, family, community, and societal levels. For the level of individual risk factors, they are linked to either the DV victim or the abuser, while the family level includes factors connected to marital issues and conflicts within the victim's family (Mojahed, 2020). For both community and societal levels, factors related to any disputes caused by extended family members, the nature of the marriage, and the cultural context, affected by both the political and religious background of the family members, are considered to explore the risk factors leading to the prevalence of DV in the Arab countries (Mojahed, 2020). Researchers

also identified the husband's SES as a risk factor for DV, particularly among low-income men, resulting in the increased likelihood of DV against their wives (Mohajed, 2020).

In a study conducted by Morse et al. (2012) to identify factors and determinants associated with IPV among a group of 70 married, healthcare providers identified five themes to address gender-based domestic violence among participants. Three of the addressed themes included and entailed the perceived causes of gender based IPV as perceived by the participants, the Arab gender role expectations being unmet, and the social norms regarding the married couple and their extended family roles (Morse et al., 2012). The same study has also found that gender-based family violence has been a theme among women who experience IPV, and gender-based family violence has also led to detrimental health problems, while still having stigma and shame associated with it, preventing women who experience it from seeking help. The prevailing lack of concern for the abuse of women by their family members or spouses can be attributed to the normalizing of punishing women for any disagreements or even perceiving such behaviors as private affairs that are never to be shared or dealt with by any third parties. Selective and misinterpreted excerpts from the Quran are frequently employed to rationalize domestic violence by portraying it as acceptable conduct commanded by God (Douki et al., 2003). Numerous studies have suggested that unemployment contributes to women's increased risk for IP (Faramarzi et al., 2005), and the same associations were found in research across Arab and Middle Eastern women (Jeyaseelan et al., 2004). The witnessing of DV by women in their family homes was also found to be strongly associated with the experiencing of physical IPV, as indicated in studies by Jeyaseelan et al. (2004) and Yount and Li (2010). The research by Simons et al. (2008) demonstrates that witnessing and experiencing DV in childhood is linked to the approval and justification of DV as an acceptable act or even perceived as "a sign of love" to the

wife in some societies (Speizer, 2009). These findings illustrate and support what many studies have found before about the tendency of the cycle of violence and abuse to persist among individuals who witnessed or experienced violence at a young age. Thus, the findings imply that the social learning model may explain what women learned from those individuals who raised them and that they only hold a subordinate place in marriage, with their men having control or power over them (Yount & Li, 2010). Socioeconomic factors such as educational attainment and economic status have also been recognized as risk factors contributing to the prevalence and persistence of DV among lower social classes. Economic hardships and financial stress often result in conflict and abuse within households, highly correlating financial stress with higher rates of DV (Sabri & Granger, 2018). Women in low-income social classes face a higher risk of experiencing unstable employment and inadequate housing, along with their lack of access to healthcare services, which leads to the worsening of power imbalances and exacerbation of certain types of abuse, such as financial and psychological abuse (Postmus et al., 2020). In developed countries, families with higher levels of education experienced lower DV rates, with higher educational levels in both spouses reported as a protective factor against violence (Campbell, 2002). This correlation is tied to higher education levels, opening the gates for independence and awareness of rights and resources among women (Yoshihama et al., 2019). Therefore, this intersection between SES and women's risk of victimization is essential to explore as a means to develop tailored therapeutic interventions and empowerment programs aimed at reducing DV rates and equipping the target population with supportive resources, such as education, housing, healthcare and employment among low-income populations.

Domestic violence remains a serious human rights violation and a concern for health among many Arab women. (Wali et al., 2020). DV has also been a major and prevalent issue

during the COVID-19 pandemic among women worldwide. In a study by Abouelenin (2022), results found women's education and employment to be contributing factors in reducing the risk of physical IPV among Egyptian women. The study also indicates that the impact of women's employment on IPV is primarily influenced by their partner's employment status. The lowest occurrence of physical IPV was found among employed women with partners who were unemployed (Abouelenin, 2022). While the risk of psychological or emotional IPV was not found to be connected to women's employment and education level, it highlighted that education and employment stand out as substantial deterrents of physical IPV among Arab women. However, no moderation effect was found on physical and psychological IPV, both before and after the rise of the Arab Spring (Abouelenin, 2022).

The Arab Spring, a series of political upheavals throughout the Arab region, sparked in the late 2010s, and it has indirectly impacted the prevalence rates of DV through the disruptions in social structures it resulted in. Due to the instability and weakened legal systems experienced during and after these uprisings, societal stressors associated with DV increased, exacerbating gender-based violence and reducing access to support services (UN Women Regional Office for Arab States, 2013).

An analysis done by the UN has found associations between violence targeted toward Arab women and societal factors in the Arab world countries, including discriminatory laws, unequal political and economic opportunities, and forced displacement (Elghossian et al., 2019). Studies also suggest that the rigid gender norms embedded in many cultures, including Arab cultures, along with male privileges and masculine notions, contribute to the widespread occurrence of DV towards women (Elghossian et al., 2019). In a research study conducted by Al-Tawil (2012), it was found that factors associated with elevated DV rates among Iraqi women

included culture, alcohol, a wife's working status, and having children. Women who were born in lower socio-economic status families and gender-stratified societies were also more prone to experience DV (Yount & Li, 2010), while other risk factors for DV were reported across women in six different Saudi cities in a study by Kazzaz et al. (2019) including alcohol or substance use by the husband and the level of education of both the woman and her husband. One significant DV risk factor that is often overlooked, particularly among Arab women residing in Arab countries, is the normalization and acceptance of most forms of DVA. The societal acceptance, alongside the lack of supportive legal regulations and laws not only perpetuates the cycle of abuse but also makes women's experiences invisible, creating barriers to seeking help in Arab societies, whereas Arab women's experiences with abuse become more invisible due to the lack of supportive laws and general society normalization.

The risk factors for DVA are multi-level, including individual, familial, community, societal, and socioeconomic influences. The cultural traditions and societal expectations have contributed to the normalization of DV in Arab societies, exacerbating the extent of abuse among Arab women. Furthermore, global and regional events such as COVID-19 and the Arab Spring caused more disruption to the social structures and support resources, leading to higher domestic violence rates. These intersecting factors are important to consider when addressing DV with Arab women and developing culturally sensitive and informed interventions for DV among Arab women. Acculturation and migration experiences add another layer to examine before building a more comprehensive understanding of the DV issue among Arab women. The acculturation processes and new sociocultural environments, along with other adaptations to the host country, influence Arab women's experiences and add to the challenges of facing domestic violence. The following section sheds light on the role acculturation plays in adding complexities to DV and

the interplay of traditional and modern values as they impact Arab women's responses to DV and their consideration of and access to support services.

Risk factors for DV among Arab women are multilayered, spanning individual, familial, community, societal, and SES levels. Prevalent and deeply embedded cultural factors, such as gender role expectations and lack of legal protections, as well as economic hardships that are unique to every social class in the different Arab societies, contribute to the prevalence and normalization of gender-based abuse against women. The COVID-19 pandemic and political instability due to the Arab Spring have contributed to the exacerbation of DV rates by disrupting social structures and limiting women's accessibility to supportive services and women's shelters. Acculturation and migration have contributed to the complication of the Arab women's experiences with DV, shaping their access to resources and responses to abuse. Addressing DV requires a comprehensive approach that acknowledges these multifaceted influences and implements culturally sensitive interventions. Another major factor contributing to the varying levels of DV severity and prevalence rates among different Arab American communities is the acculturation process. The acculturation process of Arab women who bring in their cultural beliefs, traditions, and roles can shape their DV experiences and their accessibility to mental health services and support. Therefore, the different levels of acculturation and their impact on the cycle of abuse and prevalence of DV rates are explored in the next section.

Acculturation Among Arab Americans

Acculturation is broadly described as the process through which individuals acclimate and integrate into a new host culture (Amer & Hovey, 2007). Acculturation is also the process by which immigrants in any new host country attempt to assimilate into that country's mainstream culture (Suleiman et al., 2021). Although acculturation is often referred to as the process of

cultural change, acculturation is also a process of psychological shift occurring at the contact of members descending from two distinct cultural groups (Jadalla et al., 2015). The acculturation process is unique to each cultural group, and it depends on numerous variables, including cultural and sociopolitical variables of both the immigrant and the host or majority group (Berry, 2003). The four ways in which immigrants acculturate to a country's mainstream culture are assimilation, integration, separation, and marginalization, as proposed in Berry (2003), one of the most widely recognized models of acculturation (Berry, 2003 as cited in Jadalla et al., 2015). Immigrants who assimilate to a new culture and ultimately acquire the dominant culture with a lack of interest in maintaining their own culture (Berry 2003, as cited in Jadalla et al., 2015). Unlike assimilation, integration is the process in which immigrants embrace and integrate both their native ethnic identity and that of the host country's culture. Separation is the immigrants' strategy to retain their ethnic heritage, whereas avoiding or rejecting contact with the dominant host culture. Lastly, marginalization is the voluntary or involuntary exclusion of immigrants from their ethnic and dominant culture (Chun et al., 2003, as cited in Berry, 2003). According to the Social Identity Theory (SIT), the degree to which an immigrant group experiences and perceives discrimination impacts their integration process into the host culture (Semaan, 2015). Therefore, discrimination and negative out-group experiences are among the determining factors of immigrants' stronger identification with their native culture over that of the new host environment (Semaan, 2015). Considering the range of acculturation determinant factors when working with DV victims of Arab women would be crucial as it can better explain their attitudes towards seeking professional help, giving insight to the mental health professional on what issues or concerns to address in order to normalize help-seeking behaviors. The level of acculturation among immigrant Arab women and their families directly impacts the extent to which they retain

cultural beliefs related to DV. Despite the stricter laws and regulations as well as societal attitudes towards DVA in the U.S., Arab women still face barriers to discussing their abuse experiences due to the intersecting factors of their families' or their own acculturation levels, immigration status, degree of acceptance of American gender roles, and identification with minority culture within the mainstream environment.

Acculturation can be a positive or negative experience for immigrants who experience it, and it can have either positive or negative impacts on their mental health, depending on the process or strategy through which acculturation occurs. Adaptation to a new host culture successfully includes many factors and resources that shape the acculturative process, such as generational status or age, education level, problem-solving style, and social support (Amer & Hovey, 2007). When acculturation occurs through positive psychological adaptation to the host culture, the acculturating individual cultivates a robust sense of identity, self-confidence, and overall positive mental health. Conversely, negative psychological adaptation arises when the acculturation process results in identity confusion and anxiety in the individuals undergoing acculturation (Castro, 2003, as cited in Amer & Hovey, 2007). Positive adaptation and psychological outcomes of acculturation can be predicted by the individual's acculturation strategy similarity to the acculturation approach chosen or imposed by the host culture on them (Castro 2003, as cited in Amer & Hovey, 2007). When examining the immigrants' acculturation strategies, it is essential to take into account the influence of the host country or community's reactions and attitudes towards the acculturating group (Amer & Hovey, 2007).

Research has shown that the integration strategy of acculturation is associated with the most favorable indicators of mental and psychological well-being in acculturating individuals due to its association with the social support received from ethnic and mainstream cultures

(Amer & Hovey, 2007). Literature has shown inconsistent results regarding the benefits of integration; it has demonstrated maladaptive outcomes in acculturating adults, such as acculturative stress, the stress imposed on individuals by the challenging demands of the acculturation process (Rudmin, 2003, as cited in Amer & Hovey, 2007). Acculturation stress has been found to be directly related to the acculturation strategy followed or chosen by individuals. Therefore, integration was found to be associated with lower acculturation stress levels, while marginalization was associated with the highest acculturation stress levels (Bourhis, 1997). Furthermore, research studies found separation to be related to higher stress levels than assimilation (Bourhis, 1997). Acculturation stress occurs as a result of different challenges and factors experienced by the acculturating individuals, including new customs, unfamiliar norms, language, and laws, along with the prejudice and discrimination they face in the host country (Chun et al., 2003, as cited in Amer & Hovey, 2007). Individuals with high levels of acculturation stress also tended to exhibit different psychological symptoms, including identity confusion, depression, anxiety, suicidal ideations, and even somatic complaints (Castro, 2003; Hovey, 1997).

Acculturation and Arab American Women

Acculturation and its effects on mental health patterns among the Arab American population have been understudied, as most research focuses on larger immigrant and minoritized populations in the U.S. (Amer & Hovey, 2007). The acculturation process and the acculturation stress that comes along with it are important to consider when working with immigrant minority women, such as Arab women, as they may influence the immigrant women's help-seeking behaviors and ultimately become barriers to seeking help (Brabeck & Guzman, 2008). Acculturation was found to be a predictor of improved health-related behaviors among

Arab Americans and other minoritized groups (Abuelezam et al., 2018, as cited in Sulieman et al, 2021). Earlier studies have also demonstrated that low levels of acculturation among immigrant women indicate less likelihood of seeking help and public services (Lipsky et al. 2006). Similarly, Arab Americans reporting higher heritage identity tended to experience heightened acculturative stress levels (Suleiman et al., 2021). Understanding the impact of acculturation on the incidence rates of IPV among Arab-American identifying women can aid in grasping the complexity of the various variables that contribute to and result in experiencing IPV. The intersection of identities among Arab immigrant women is further proof that the experience of IPV is not uniform, even among women from the same ethnic background. The acculturation process comes with new life circumstances and situations that can contribute to immigrant women remaining in their abusive relationships (Kim & Sung, 2001). These new life conditions and circumstances entail experiences that are linked to IPV prevalence among immigrant women, such as the struggle to obtain employment, resulting in immigrant families suffering financially and interpersonally, with the men of the households facing the stress of not fulfilling their primary roles as primary financial providers for their families (Wallach et al., 2010).

The acculturation process for immigrant women is often characterized by different help-seeking barriers that include but are not exclusive to their loyalty to family cohesion, fear of breaking family expectations, and concerns about deportation, which make it progressively challenging for many immigrant women to seek any form of professional help following DV incidents (Brabeck & Guzman, 2008). These help-seeking barriers prevent women from receiving the help they need and can result in many adverse mental health consequences, including depression, anxiety, social withdrawal, and PTSD among immigrant women (Bonomi

et al., 2009). Although White women and immigrant women may experience similar physical and psychological consequences to IPV, immigrant women are also faced with the disadvantages that come with their immigration status, including their limited access to resources, lack of social support, discrimination, tolerant and justifiable attitudes towards IPV, and language proficiency levels of their host country. These accumulated factors make it more complicated for immigrant women to break the cycle of violence and seek help when experiencing IPV. In a study by Khan et al. (2021) highlighting the disadvantages experienced by immigrant women, 12 out of 15 participants (80%) reported viewing IPV as widely accepted and normalized in the Arab American community, while four participants (26.6%) reported that Arab American women's acceptance of IPV is an attempt to avoid larger conflict and shame associated with speaking up about it. One participant in the same study reported that married IPV victims and survivors who manage to leave their abusive partners face negative reactions from their partners and their own families (Khan et al., 2021). These findings incorporate the stress theory suggesting that low-income increases stress within the family, which may result in husbands committing domestic violence against their wives (Smith, 1990). Other scholars argued that the husband's or the household's overall economic standing does not solely indicate the risk of women experiencing DV. However, instead, the woman's financial dependence is a more accurate indicator of the likelihood of experiencing DV (Anderson, 2005).

Acculturation is a long and complicated process that faces immigrants as they settle into their new host country. The four acculturation strategies followed by immigrants are assimilation, integration, separation, and marginalization. Depending on the acculturation strategy followed by the immigrant individuals, the consequences change to make it less or more challenging to settle into and build a new life in the new host country. Immigrant Arab women

are no exception to the challenges faced by immigrants in their new host countries, which include a lack of social support, limited awareness of available resources, language barriers, fear of deportation, and various stressors associated with the acculturation process. These acculturation factors, along with individual factors such as cultural ideas and beliefs about IPV, play central roles in perpetuating the cycle of violence and the high occurrence rates of DV among immigrant Arab women.

Domestic Violence and Immigration

Domestic violence is also a prevalent issue within the Arab communities of immigrants and refugees, disproportionately impacting Arab women's lives. It has been observed that DV resulted in the loss of more lives among women of minority groups than women from the Western majority groups (Abu-Ras, 2007). Although in Western countries, immigrant Arab women might have greater access to social organizations and services, as well as mental health services, compared to their home countries, Arab immigrant women still face more difficulty in seeking those services as they remain living in higher-risk situations and under strict cultural conditions, preventing them from seeking and utilizing such services safely (Abu-Ras, 2007). Among Arab immigrant women, DV risk factors remain similar to those among Arab women in the Middle Eastern region with the addition of the new stressors of immigrant status and the newly acquired socioeconomic status of the family (Abu-Ras, 2003). The duration of residence in the new country and marital status after immigrating are also significant risk factors that can lead to DV among Arab women (Abu-Ras, 2007), especially if they lack support systems in their new country of residence. Traditionally, marriage continuity and holiness of the family are emphasized in the Arab culture, along with the family's desire to save face over any conflicts in the marriage (Abu-Ras, 2007). Thus, those considerations can play a major role in the

underreporting of DV cases reported by immigrants who are victims or their family members due to the overvaluing of the continuity of marriage in an attempt to save the family from division. The societal norms and traditional values force many women from an Arab background and Arab immigrant women to remain in abusive marriages to avoid the shame and consequences associated with separating from or divorcing their abusive partners, include loss of income or financial resources, loss of children's custody, and possible social ostracization and harassment, along with blackmailing from their former husbands (Haj-Yahia, 2002).

The prevalence of IPV in communities from an Arab background and the immigrant Arab community in the U.S. is understudied. Yet, the scarce studies examining the incidence rates of IPV among Arab Americans report higher rates of DV and IPV targeting women from an Arab American background. In a study conducted in Dearborn, Michigan, by Abu-Ras (2007), it was found that 28% of local arrests involving Arab Americans were due to domestic violence acts. Higher prevalence rates of physical DV and partner-controlling behaviors were reported among Iraqi Americans in Detroit, with a 93% prevalence rate (Barkho et al., 2011). Lastly, acquiring a deeper comprehension of the unique risk factors that Arab women face can be informative to clinical psychologists in developing culturally sensitive DV prevention and intervention techniques and strategies that are specifically tailored to this unique population.

The discussed levels of risk factors, including individual-level, family-level, community-level, and societal-level factors, all play important roles in the continuation of the cycle of abuse. Thus, it is crucial to comprehend the uniqueness of these multi-leveled factors among Arab women for more effective treatment approaches and interventions when working with them. Understanding the cultural identity of women from immigrant Arab backgrounds and the importance of family reputation and wholeness is crucial before working with them, as it

explains their approaches to dealing with DV and their choices when it comes to addressing it. As important as it is to discuss the risk factors that lead to the prevalence of DV among Arab women, it is even of more important to discuss DV protective factors that Arab women would be capable of safely utilizing to prevent or early intervene with their experiences of DV. The next section discusses the under-researched area of protective factors among this study's population and how it ranges from social support and family ties to a woman's economic capital including education and a career to be factors that can mitigate the reoccurrence of DV experiences to prevent women from exposure to IPV altogether.

Acculturation among Arab Americans is a complex process influenced by multiple cultural, psychological, and sociopolitical factors. The acculturation process significantly impacts Arab women's mental health, patterns of seeking help, and experiences of DV. Other factors impacting Arab women's integration process to the host society include their cultural beliefs about DV, fear of deportation, financial dependence on their perpetrators, and limited social support, which often prevent them from seeking mental health or legal help. Additionally, the acculturation strategy chosen or imposed upon them affects their overall psychological well-being, with integration generally associated with the most positive mental health outcomes. Therefore, it is crucial to develop a deeper insight during the intake and treatment processes of the intersection between acculturation and IPV among Arab American women to develop culturally sensitive interventions and support systems that address their unique challenges and needs.

The discussion of the acculturation process and levels necessitates consideration of cultural beliefs that contribute to differences in adapting to a specific acculturation level.

Therefore, the next section highlights the cultural beliefs impacting the prevalence rates of DV among Arab women and emphasizes the protective factors impacting DV rates.

Cultural Beliefs and Protective Factors Impacting DV

Middle Eastern and Arab terms are often used interchangeably with the misconception that they both refer to the same culture or describe individuals from the same region. However, the Middle Eastern and Arab cultures are two distinguished cultures that may share similar languages, customs, and traditions due to their approximate geographical locations. In order to discuss their similarities and differences, there is a need to define each term separately. The term Arab refers to the ethnolinguistic category of individuals who speak and share the Arabic language with different spoken dialects and come from ethnically diverse backgrounds. The term Arab typically describes individuals who reside in any of the 22 countries that make up the League of Arab States. Although individuals from these countries may speak the Arabic language, they might not identify themselves as Arabs as they descend from other non-Arab ethnic backgrounds (TeachMideast, 2017). On the other hand, the term Middle East is a Eurocentric geographic term that was only coined by the British in the nineteenth century to describe the area between the British colony of India, the Balkans, and the western part of the Ottoman Empire, or modern-day Turkey (TeachMideast, 2017). The Eurocentricity of the term comes from the region being east only from the perspective of Western European countries and not any other countries. The Middle East or Middle East and Northern Africa (MENA) consists of a variety of countries that make up North Africa, including Algeria, Tunisia, Morocco, Libya, and Egypt, and the countries to the east of Europe, including Lebanon, Syria, Palestine, and Jordan. Historically, the Middle East has been a predominantly Muslim region that shared a common cultural and religious heritage with the Arab world (TeachMideast, 2017). According to

Northwestern University in Qatar [NU-Q] (2018), the Arab countries range between conservative and more liberal; however, most Arab countries identify as culturally conservative, except for Lebanon, which equally identifies as both conservative and progressive. In Jordan, Qatar, and Saudi Arabia, seven in ten individuals identified as either somewhat or very culturally conservative, while the frequency was six in ten Egyptians (NU-Q, 2018). The same survey has also found that older Arab individuals were inclined to self-identify as more culturally conservative relative to younger Arab individuals, while younger Arabs were three times more likely to identify as progressive than older Arabs (NU-Q, 2018). Although these findings can give hope for the newer generations of Arab women, as the more progressive new generations of Arab men may support them in challenging the cultural beliefs, social norms, and gender norms in the Arab culture, leading to the prevalence of DV among Arab women, these findings do not guarantee Arab women their rights or safety when faced with their abusers.

The findings about the higher statistics of Arab individuals self-identifying as progressive still do surpass the numbers of conservative Arabs, and the same survey has found that both conservative and progressive Arabs still share the same attitudes about preserving the cultural traditions (NU-Q, 2018). Therefore, psychoeducation and raising awareness on some of the harmful cultural traditions and beliefs that lead to the prevalence of DV in Arab societies is needed in order for Arab women to experience the progressiveness of the younger generations that are now more vocal in society. It is also crucial to recognize that Arab societies are still considered conservative compared to the Western world today, affecting women's status and how they live under the consequences of male supremacy beliefs. These beliefs cause the domestic violence rates and issues to continue as they innately give men the privilege to discipline women and treat them like second-degree citizens (Kisa et al., 2021). Also, having

male supremacy beliefs in Arab society, along with the early marriages of minor girls and young women does not only leads to forced unsuccessful marriages but also leads to many domestic violence cases and even honor killings, consequently (Kisa et al., 2021). Patriarchal cultural norms and family honor being tied to the women of the family are two structural cultural factors that result in the prevalence of DV across the population of Arab-American women (Kulwicki et al., 2015). Research has also revealed that as Arab women submit to the cultural gender roles in marriage, their experience of IPV and view of it start to get influenced to the extent of preventing them from seeking professional help and IPV supportive services (Aswad & Gray, 1996; Kulwicki, 2000).

In a study by Abu-Ras (2007), 67 Arab American women were interviewed to examine the cultural beliefs that play a role in help-seeking and help-avoiding behaviors among battered Arab women in the U.S. It was also hypothesized that the traditional attitudes that Arab women bring with them to the U.S. cause them to become targets of DV and less likely to seek services that support victims of DV (Abu-Ras, 2007). The study findings indicated that 49% of the participants reported being financially dependent on their husbands as their primary source of income (Abu-Ras, 2007). These findings align with the cultural gender expectations of the Arab culture, in which men are the primary providers of the household, contributing to the financial abuse experiences encountered by many Arab women.

Patriarchal beliefs, cultural beliefs such as those related to gender roles, help-avoiding behaviors, and financial dependency are the main Arab cultural norms and beliefs discussed in this section to explain how these factors play a role in causing Arab women to become targets of DV as well as less likely to seek supportive services during or after their DV experiences.

These Arab cultural norms and beliefs extend to include some severe forms of DV, such as Female Genital Mutilation/Cutting (FGM/C) and honor crimes against Arab women. Therefore, FGM/C and honor crimes are briefly discussed in the next section to shed light on their continuing practice in some Arab regions to our current day. These two cruel forms of DV do not only result in the previously discussed DV effects, but they also lead to Arab women losing their lives for their families or partners to continue living by the societal norms.

The therapist's knowledge of these cultural similarities and differences between the Middle Eastern and Arab cultures can aid in the building of therapeutic relationships with clients from these cultural backgrounds. It is particularly important to differentiate between both cultural backgrounds to gain a deeper insight into the distinct risk factors leading to DV and the beliefs that result in Arab women staying in abusive relationships. This knowledge and awareness can help to early-prevent countertransference-related issues as well as any rupture in the therapeutic relationship due to the clinician's lack of awareness regarding the client's cultural beliefs, customs, social norms, and values. In addition to gaining knowledge about their clients' cultural backgrounds, mental health providers face the need to be trained in the different evidence-based treatment modalities tailored to address DV. Intervention modalities such as Cognitive Behavior Therapy for Battered Women (CBT-BW) and Interpersonal Therapy (IPT) have demonstrated effectiveness in addressing the psychological and emotional needs of DV survivors. The following section will explore these intervention modalities alongside other therapeutic approaches to equip clinicians with a wide array of treatment approaches addressing DV to meet the diverse needs of women with varying DV experiences, ensuring culturally sensitive supportive services.

Although a growing progressive shift among Arab Americans of the second and third generations is evident, the deeply rooted patriarchal values and male supremacy beliefs continue to shape Arab individuals' attitudes towards DV. Financial dependency, cultural expectations of women's roles, and help-avoiding behaviors are cultural factors that continue to contribute to Arab women's vulnerability and reluctance to seek support. Moreover, severe forms of DV, including Female Genital Mutilation/Cutting (FGM/C) and honor crimes, call for an urgent need for culturally informed DVA interventions as a means to save young girls' and women's lives. Mental health professionals must develop an in-depth understanding of these cultural complexities to provide effective, culturally competent services tailored to DV survivors' needs utilizing evidence-based approaches such as Cognitive Behavioral Therapy for Battered Women (CBT-BW) and Interpersonal Therapy (IPT).

Global Interventions Utilized with DV Victims of Women

Interventions for DV address multiple different aspects of IPV besides physical abuse, including safety, immediate and prolonged impact, trauma processing, and re-victimization (Condino et al., 2016). The battered women's movement, which emerged during the 1970s, is considered the catalyst for changes in the therapeutic interventions used for DV, along with the growing understanding of the criticality of DV as a health issue that compromises the safety of its victims (Schechter, 1982). It has also helped pave the road for various IPV approaches, including the community-action approach as one of the most expanding and encouraging IPV interventions used to address IPV for children and adults. A study by DePrince et al. (2012) has demonstrated that community-based outreach resulted in reduced levels of distress reported by IPV victims. A similar study conducted by Graham-Bermann et al. (2007) employed an alternative community-based intervention with children exposed to DV and found that the

intervention resulted in diminished occurrences of internalizing and externalizing behaviors in children. Heise (1998) described how the same community-based intervention approach has been used for an IPV offenders' program employing the ecological model framework approach, and the program focused on diminishing risk factors while enhancing protective factors associated with violence towards women by analyzing the individual, interpersonal, situational, and social factors of the offenders (Lila et al., 2010).

Psychologists in Europe and the U.S. have been conducting research, clinical evaluations, and interventions to contribute to the prevention of IPV (Condino et al., 2016). Some of the most effective DV prevention projects are led by the *Asociación de Asistencia a Víctimas de Agresiones Sexuales y Violencia de Género* (ADAVAS), and they prioritize efforts aimed at addressing and reducing the incidents of sexual abuse and DV through educational programs for children and adolescents about gender equality (Condino et al., 2016).

The different types of programs addressing DV offer women a variety of services utilizing approaches that speak to the victims or the abusers. For example, the ADAVAS has implemented programs consisting of support groups for women who experienced DV (Condino et al., 2016). In the United Kingdom, the United States, and Canada, interventions and therapeutic programs addressing DV often include compulsory programs for the abusers, utilizing a pro-feminist approach to emphasize and deconstruct the violence associated with male strategies of power and control over women in their relationships (Adams, 1989; Pence & Paymar, 1993). The research literature supports the use of counseling and structured therapy as interventions to reduce the negative effects of DV that go beyond physical injuries, in particular, PTSD and depressive symptoms (Eckhardt et al., 2013). In most IPV interventions and support

groups, participants are not directly encouraged to end their abusive relationships but are rather educated on their rights and empowered to take control of their lives (Condino et al., 2016).

Interventions for IPV exist across different medical and mental health settings, and they utilize various treatment modalities, often emphasizing follow-up care post-discharge from the DV shelters (Condino et al., 2016). One of the most prevalent modalities in IPV interventions is CBT, and the two notable CBT programs often utilized to target DV survivors of women are Cognitive Trauma Therapy for Battered Women (CTT-BW) and the Helping to Overcome PTSD through Empowerment (HOPE) treatment program (Kubany et al., 2003, 2004; Johnson et al., 2011). CTT-BW is a multi-component cognitive trauma therapy intervention designed to address PTSD symptoms in women who encountered physical and/or sexual abuse at any stage of their lives (Kubany et al., 2003, 2004). CTT-BW works on the roles of guilt and shame beliefs associated with IPV that result in maintaining PTSD symptoms, using cognitive-behavioral techniques such as psychoeducation, stress management, cognitive restructuring, and exposure-based interventions (Kubany et al., 2003, 2004). These CTT-BW cognitive-behavioral-based interventions aim to use self-monitoring along with cognitive restructuring techniques to address the negative self-talk and self-blame experienced by most IPV victims and survivors of women (Kubany et al., 2003, 2004). The modality of CTT-BW is usually 8-11 sessions of individual treatment with women who have been out of their abusive relationships for at least 30 days, have no intentions of reestablishing relationships with their abusive partners, and have met the diagnostic criteria for partner-abuse-related PTSD (Kubany et al., 2004).

The HOPE program is another brief treatment program of 9-12 sessions for battered women that utilizes CBT-based interventions for female shelter residents (Johnson et al., 2011). The HOPE program focuses on supporting women in accurately evaluating the DV threat level

when exposed to it and providing women with techniques and skills to effectively manage their PTSD symptoms without compromising their safety (Johnson et al., 2011, 2016). Similar to the CTT-BW, the HOPE program provides psychoeducation about IPV, PTSD, and safety planning for IPV women survivors (Johnson et al., 2011). One primary focus of the HOPE program is emphasizing the need to work in collaboration with DV case managers and other resource providers, as emphasized in Johnson et al. (2011), as a means to strengthen the program's core principles related to empowering women. The adapted iteration of the HOPE program expands to include 6 more sessions following the shelter stay in addition to the main 10 sessions conducted during the stay at the shelter, to re-evaluate the goals and safety of women participants and reinforce the previously learned treatment interventions (Johnson et al., 2016).

Zlotnick et al. (2011) explored the efficacy of Interpersonal Therapy (IPT) among low-income pregnant women who were victims of IPV. The results indicated moderate effectiveness of IPT in reducing PTSD and depression symptoms during pregnancy as well as large effects in reducing PTSD symptoms in women up to 3 months postpartum. In another study by Cort et al. (2014), the findings of IPT treatments indicated positive posttreatment interpersonal functioning changes and a reduction in the severity of depression symptoms in women with IPV histories.

According to Wang et al. (2005, as cited in Cort et al., 2014), IPT administered in a community agency was found to be much more well-received by women participants, as evidenced by treatment completion rates, than in traditional outpatient mental health clinics. This finding suggests that the type of treatment setting can play a role in accepting new treatments by women with IPV histories. IPT groups for victims and survivors of IPV have also demonstrated success in alleviating the severity of depressive symptoms as well as facilitating the development of social skills among women participants (MacKenzie & Grabovac, 2001).

Women who developed depressive and PTSD symptoms due to their exposure to interpersonal trauma have been found to have a greater vulnerability to encountering future instances of IPV (Iverson et al., 2011). This finding suggests that IPV interventions targeting perpetrators may have limited efficacy in treating the psychological effects of IPV, as it can be interpreted as victim-blaming among IPV victims of women (Dutton, 2009). Due to the implication of depressive symptoms as risk factors for general IPV revictimization, Cognitive Processing Therapy (CPT), a variation of cognitive behavioral therapy that is proven to be effective in minimizing depressive and PTSD symptoms, has been utilized among women with IPV histories (Iverson et al., 2011). The goal of the study by Iverson et al. (2011) was to examine the association between the reduction of depressive and PTSD symptoms due to engagement in treatment and future IPV revictimization among women with histories of IPV. The study results indicated that women who reported milder depressive and PTSD symptoms during the CPT treatment period reported fewer incidents of IPV at a six-month follow-up, in contrast to non-participating women (Iverson et al., 2011). This study opens the door for experimenting with more psychological interventions in hopes of preventing future IPV among women with IPV histories, as the interventions help in reducing the negative psychological effects.

The discussion about the commonly used IPV interventions is better explained and understood through the catalysts of the movement for battered women and the grassroots movement, which allowed for the research and development of IPV interventions and provided women with safe DV shelters. The literature in this section also indicates that the discussed community-based approaches, such as the CTT-BW and HOPE programs, which provide women with support and empowerment through therapy and other resources, have been found effective in lowering distress levels among IPV victims. The different therapy approaches of CTT-BW,

IPT, and CPT have been shown to contribute to the reduction of the adverse psychological effects of IPV, as indicated in the alleviated symptoms of depression and PTSD reported by victims and survivors of IPV. These IPV intervention approaches have also been found to facilitate self-esteem and social skills among women as well as reduce guilt and shame beliefs associated with speaking up about IPV. Although the discussed IPV intervention approaches are commonly used across settings and populations of women worldwide, it is crucial to consider whether these approaches would be culturally appropriate for the populations they are utilized and intended for. The interventions with DV victims of Arab American women section discusses the role that the immigration status and marginalized identities of these women play in putting them at a disadvantage when it comes to having fewer human resources and social networks, placing them at an increased risk for encountering IPV.

It is also important to include the impact of both the culture of origin as well as traumas related to immigration and acculturation. An observational study of DV perpetrators, focusing on Latino men who had resided in the U.S. for less than a year, found that an effective intervention had to begin with accepting the men's cultural background and addressing the personal crises related to immigration and acculturation. This culturally sensitive approach was identified as essential for working towards eliminating these men's abusive treatment of family members (Hancock & Siu, 2008). Understanding the influence of these factors would also be beneficial when working with the Arab American women population, highlighting the necessity for culturally appropriate approaches to guide service delivery. Cognitive-behavioral interventions, such as Cognitive Trauma Therapy for Battered Women (CTT-BW) and the Helping to Overcome PTSD through Empowerment (HOPE) treatment program, have been found to alleviate PTSD symptoms and empower DV survivors. Interpersonal Therapy (IPT) and

Cognitive Processing Therapy (CPT) have also shown effectiveness in reducing depressive symptoms and enhancing interpersonal functioning among IPV survivors. The effectiveness of these interventions varies depending on cultural appropriateness, highlighting the need for culturally sensitive approaches when working with Arab American women. The global interventions for DV may involve some components that are culturally appropriate to utilize with Arab women; however, the next section aims to hone in on culturally sensitive interventions that consider the cultural background, societal norms, traditions, and customs of the Arab culture when working with Arab women to ensure effective treatment.

Interventions with DV Victims of Arab American Women

Immigrants face multiple challenges as they move to settle in a new country, and their challenges in their new country of residence are influenced by different factors that they bring along with them, including their SES, educational level, religious beliefs, and traditions. In a study by Bui and Morash (1999), it was found that immigrant women who come with disadvantages in social status and human resources exhibited lower chances of active participation in social networks compared to immigrant men (Abraham, 2000b). This vulnerability in particular may serve as a primary risk factor contributing to increased rates of DV among immigrant Arab women. It also can explain subsequent inequalities and limited access to culturally sensitive and safe social and mental health services. Arab immigrants bring their sociocultural norms and practices to the U.S., making the reporting of DV incidents difficult and even life-threatening for the DV victims who turn to support beyond the circle of their family and acquaintances from the same cultural background. In other instances, immigrant Arab women may be able to utilize social and mental health services, yet they may not have the ultimate decision in accessing these resources safely (Menjívar & Salcido, 2002). Although the

difficulty of accessing supportive resources can stem from the shame and negative societal judgment linked to seeking legal or psychological services, it can also be a direct result of the limited social networks and self-isolation experienced by women due to their immigration status.

Among the Arab American community in Michigan in 1993, there were 34,505 domestic violence and assault cases and 45 homicide cases involving a form of domestic violence reported (Michigan Department of State Police, 1993). According to the Michigan Department of Public Health, Task Force on Interpersonal Violence Prevention and Reduction (1994), the incidence levels of DV crimes are higher within minority communities, resulting in a greater loss of lives in comparison to the white American population. Despite the higher DV rates among Arab immigrant women, Arab women remain averse to seeking or receiving social services or interventions in IPV cases. This is evident through the notably low rates of DV incident police reports filed by Arab women (Aswad & Gray, 1996). The reluctance of Arab American women to pursue mental health services and supportive services following their DV experiences can be due to the expectations put on Arab women within the Arab immigrant community to follow traditional values regarding marital and gender-role expectations (Abu-Ras, 2007). Although the cultural expectations placed on Arab women can be leading factors to their aversion to seeking different supportive services, the fear of discrimination and lack of culturally sensitive interventions in both legal and mental health services remain strong barriers to seeking the available IPV supportive services by Arab Women (Barkho et al., 2011). Language can also be another barrier to utilizing IPV supportive services, making it crucial to employ professionals who can speak the language of the populations they serve. Therapists who worked with predominantly the Arab American population reported other obstacles in providing services to this population due to disinclination of the idea of partnership with the mental health provider

rather than having the traditional hierarchy of roles of a doctor and patient (Mourad & Carolan, 2010). Thus, it is not only seen as shameful but also a betrayal to divide and expose the family by speaking up or reporting their DV incidents to strangers. The general distrust of the mental health provider's ability to maintain confidentiality requires more culturally sensitive providers who have the capacity to facilitate alliances with Arab women, utilizing a more directive role in treatment.

Research and previous studies indicate that the occurrence rate of DV among Arab women is higher than the DV rates around the world. The national laws, the gender roles, the social life and factors, and the religious doctrines that are still followed put Arab women in a position more prone to experience DV. These same laws, doctrines, and traditions make it harder and more dangerous for Arab women to speak up about their domestic violence experiences or seek help from a professional. Thus, psychoeducation about DV and its adverse impacts on women's bodily and mental wellness would be a crucial intervention to raise awareness and educate women about their rights. Psychoeducation about the available resources that women can have access to and the type of support each resource provides would also be crucial to provide Arab women to ensure their safety.

In many Middle Eastern countries, DV remains considered a family concern, and it is not treated as a serious violation, public health threat, or legal issue (Kulwicki & Miller, 1999). As with many immigrant communities, Arab women within the Arab immigrant community are still expected to adhere to the traditional values concerning marital and gender-role expectations (Abu-Ras, 2007). Within the Arab immigrant community residing across the states, the anti-Arab political climate following 9/11 also had a major impact on deterring Arab immigrant women from seeking any social or professional services, including contacting the police, in fear that it

may expose them or their families to political harassment (Abu-Ras, 2007). Thus, providing Arabic-speaking professionals or professionals with similar cultural and ethnic backgrounds as Arab women may help draw Arab women towards seeking those types of services, as they would feel safer and more relaxed talking to professionals who understand their cultural traditions, norms, and beliefs.

The immigration status of Arab women in American society indeed plays a significant role in shaping and even limiting the help-seeking behaviors of Arab women victims of DV. That directly occurs due to their immigration status putting limitations on their human resources and social networks. Also, the shame and guilt surrounding speaking up about DV, which means speaking up against a partner or a family member, are the cultural norms that keep the continuous cycle of DV among women. The same shame and guilt surrounding speaking up about IPV also surround help-seeking behaviors which are crucial to consider when choosing DV interventions to use with Arab women victims. Although having knowledge about Arab cultural norms and beliefs when working with Arab DV victims of women would assist in better understanding and building a therapeutic relationship with Arab women, language may remain a barrier, particularly when working with DV victims of newly immigrated Arab women. The language barrier makes it more challenging for women to utilize or benefit from IPV interventions and resources, regardless of their help-seeking attitudes. Therefore, it is of great importance to train Arabic-speaking professionals to not only ease access to resources but also encourage Arab women to seek professional help when exposed to any DV behaviors, which would gradually result in some change in the prevalence numbers of DV among Arab women.

Recommended Interventions for Arab Women

Most research on DV among the Arab American population focuses on the causes and risk factors of DV as well as barriers to the utilization of supportive services by victims. The patriarchal cultural norms, family honor beliefs, and victim blaming are among the structural factors leading to the prevalence of IPV among Arab women (Kulwicki et al., 2015). Additional factors serve as barriers to utilizing supportive services for Arab American women, including fear of discrimination, struggle to obtain a divorce or escape a perpetrator, lack of family and societal support, and lack of culturally sensitive approaches (Khan et al., 2021). Culturally appropriate approaches must account for cultural norms and expectations as they pertain to sensitive topics in the Arab culture, such as the overarching topic of IPV, particularly concerning physical and sexual abuse issues among Arab American women. The wide acceptance and normalization of IPV in the Arab culture has made it an issue dealt with privately in an attempt for women to avoid larger conflicts with their families and their Arab American community. In the study by Khan et al. (2021), some participants perceived psychological IPV as the most commonly experienced form of IPV and identified it as a precursor to future physical IPV in the Arab American community. Although physical IPV was openly discussed in the same study by Khan et al. (2021), sexual IPV was perceived as sensitive and too private to discuss openly both within and outside the context of the research study. Other participants discussed rationales for married and unmarried victims of Arab women's choices to not disclose IPV emphasizing the consequences of fear of shaming their families in the community, getting pressured to remain in the marriage, worrying about the impact of leaving their partner on their children, and receiving threats about potential blackmailing in the case of unmarried women. It is crucial to acknowledge these different challenges experienced by Arab American women to quit the

Western approaches for DV and rather tailor culturally sensitive approaches that cater to the unique experiences and needs of this minoritized population.

Mental health professionals must consider the accessibility and availability of IPV support services within the Arab community before discussing recommended culturally appropriate interventions for their DV victims of Arab women. The supportive resources within the Arab community varied to include family, friends, and religious leaders, such as sheikhs and imams, who were reported to be effective advocates in educating Muslim Arab communities about IPV and mediating IPV cases among the community (Khan et al. 2021). Moreover, studies on IPV among Arab women in both the Middle East and the U.S. have revealed that faith communities are often the first contact point for IPV survivors of women seeking help due to their knowledge of the religious and cultural values and traditions within the Arab community (Abu-Ras, 2007). This knowledge would be crucial in informing culturally sensitive approaches for IPV among Arab American women, as it provides mental health professionals with liaisons for IPV awareness and support for women who may not have other protective and supportive systems. The current domestic violence interventions and programs tend to follow Westernized approaches in treating the effects of domestic violence, highlighting the need for developing culturally appropriate DV interventions to adequately address the prevalent issue of DV within diverse communities of women. According to the American Psychological Association (APA), culturally appropriate interventions are those tailored specifically to a target population's cultural beliefs, values, norms, and practices (APA, 2017). An intervention is considered to be culturally appropriate when it incorporates the served population's cultural background, including values, norms, language, customs, and traditions into the therapeutic process to ensure providing relevant and respectful treatment to the individuals' cultural context (APA, 2017; Robinson et

al., 2002). A study by Erikson and Al-Timimi (2001) highlights the importance of considering central values and psychosociocultural factors in tailoring culturally appropriate treatment goals with the Arab population. Arab individuals' tendency to somaticize emotional pain is explained to be a result of various factors, including cultural stress and limited terminology describing mental states in Arabic (Meleis, 1982, as cited in Erikson & Al-Timimi, 2001). Therefore, interventions incorporating psychoeducation that provide culturally relatable explanations and utilize appropriate language considering the culture, religion, and attitudes of DV victims of women toward mental health services would aid in the building rapport process and help clients feel more connected and at ease to seek mental health professionals.

Consequently, DV interventions and programs for Arab women would benefit from incorporating psychoeducation and increasing emotional awareness of different mental states, particularly those commonly associated with the effects of DV, such as depression and anxiety. These culturally sensitive interventions would serve as support systems by providing women with the space and knowledge that allows them to articulate their abuse experiences without fear or shame. Mental health professionals must familiarize themselves with the Arab culture and the predominant concepts Arab women would carry into treatment, such as the focus on the other or the family, leaving less space for self-examination or reflection on their abuse experiences or unmet needs in relationships (Gorkin et al., 1985, as cited in Erikson & Al-Timimi, 2001). The Arab culture is inherently collectivistic, emphasizing the role family, religious leaders, and faith community play as effective and immediate support systems. Arab women's connections to these systems can also influence their awareness of and access to domestic violence supportive services and programs (Khan et al., 2021). Individuation talk is another factor that may impact Arab women's willingness to open up for treatment or even continue services; therefore, mental

health professionals must carefully assess Arab women's goals regarding their relationships with family and the faith community as a part of therapy goal planning and building the therapeutic alliance (Erikson & Al-Timimi, 2001).

Community-based approaches become fundamental treatment approaches to lean into when working with victims of Arab women, particularly newly immigrated Arab women, to utilize support groups led by trusted leaders to empower women and offer them direct services. The type of direct services provided in community service approaches that would be culturally appropriate for Arab women varies from relocating or housing assistance and legal issues to job training and services for any children who the abuse has impacted. Language barriers and familiar terminology are critical to account for in the community service treatment approaches to provide clients with interpreters who speak their dialect and culturally competent service providers to build better rapport and communicate effectively with Arab women with different acculturation levels. Erikson and Al-Timimi (2001) discussed multiple culturally specific issues that require addressing when implementing treatment strategies with Arab women, among which employing exploration techniques to help Arab women to mitigate ingrained negative perceptions of mental illness and psychological treatment services, as well as the employment of psychoeducation and empowerment strategies to help clients cope with their concerns and mental health symptoms. As helpful as these strategies are in the treatment process with Arab women, helping victimized women feel seen and heard by taking the time to learn about their identities, cultural values and beliefs, and their current difficulties and expectations for treatment remains the backbone of the therapeutic process, which supports victims and survivors of DV in their healing journeys. These approaches and strategies can be implemented by either culturally competent mental health professionals or through collaboration with Arab religious and

community leaders to promote awareness about DV and reinforce anti-violence messages in the community that are informed by cultural values, traditions, and religious teachings to foster and normalize acceptance of DV intervention programs.

Arab women who experience DV face additional challenges that are unique to their sociocultural norms, immigration status, language barriers, and limited access to culturally sensitive resources. The reluctance to seek professional help is the outcome of various beliefs and factors, including patriarchal traditions, fear of community backlash, and distrust in Western psychological interventions. Community-based approaches, psychoeducation, and culturally competent mental health professionals are essential factors to providing effective and safe interventions for Arab American DV survivors. The evidence-based programs and approaches for treating victims of DV are in the rise; however, the approaches specialized in the treatment of minoritized battered women are scarce in comparison. The next section aims to discuss some recommendations to consider when utilizing pre-existing treatment modalities when working with Arab women to tailor the therapeutic process to address their unique needs from a culturally sensitive lens.

Conclusions and recommendations

Mental health professionals working with and treating women victims of DV may face some unique cultural, traditional, and sociocultural differences when working with Arab women experiencing DVA. Therefore, this section aims to present a culturally sensitive model of treatment along with culturally appropriate recommendations to utilize in clinical and therapeutic work for battered women. The treatment recommendations offer clinicians approaches that are culturally sensitive to assist in the normalization of accessing and receiving mental health support among the target population.

The Arab population shares similar cultural beliefs and traditions; however, individuals of Arab descent come with diverse religious backgrounds, sociocultural status, immigration status, acculturation levels, and varying self-perceptions of the intersectionality of their cultural identities. The collectivistic nature of Arab societies requires clinicians to incorporate cultural background in the utilized therapeutic interventions. The community-based approaches and programs have been tailored to accommodate the different needs of ethnic minorities based on selected practices from Evidence-Based Practice (EBP) models for DV. The community-based approaches as models of treatment offer a holistic and greater understanding of the intersecting factors and systems involved in the cycle of abuse, which the clinician can utilize in the process of treatment with domestic violence victims from the minoritized population.

Culturally informed empowerment-based interventions are strategies within community-based approaches that address the unique needs and systemic barriers faced by minoritized women through recognizing their cultural values, such as collectivism, spirituality or religiosity, face-saving, and interdependence. Therefore, clinicians may benefit from less structured clinical interviews that focus more on rapport building to gain Arab clients' trust to continue seeking treatment and disclose their experiences, resulting in the rise of their psychological distress or compromised safety. Given the importance of family cohesion, social norms, and face-saving values, clinicians must approach Arab women from a humanistic, non-judgmental stance to support them in processing their DV experiences and challenge the shame and stigma associated with speaking up about DVA perpetrators of family members. The mainstream culture is individualistic with some awareness of the issue of DV, making it less stigmatized for American women to seek mental health services or discuss their DVA experiences. Thus, Arab women may experience more difficulties in soliciting any type of support from their family or social group

due to their culture's collectivistic nature and the interdependence among family members. In this case, psychoeducation becomes a mandatory intervention to utilize with Arab women through implementing psychoeducational programs and groups to empower women and inform them about forms of abuse, the cycle of abuse, their legal rights, and the effect of DV on emotional health and wellness.

The clinician may also benefit from utilizing motivational interviewing techniques, as it provides a supportive and empowering framework for the clients to not only process their feelings but also explore and balance decisions about their safety and well-being. Motivational interviewing strategies share multiple similarities with the previously recommended humanistic approach; therefore, it would re-assert the clinicians non-judgmental and empathetic approach, which would allow DV victims to feel heard, validated, and seen without feeling shamed or pressured. The reflective listening, affirmations, and open-ended questions motivational interviewing utilizes would assist in reinforcing women's autonomy and self-efficacy to start making the choices that would best fit their healing journeys.

In order to gain a greater level of insight into the individual needs of each Arab woman through the utilization of the previously discussed therapeutic approaches, clinicians may also benefit from utilizing the biopsychosocial model during the assessment process to explore the level of family cohesiveness, SES, spirituality/religiosity, acculturation style, and conformation to cultural roles through the holistic framework of the assessment model. These factors can function as risk factors contributing to the continuation of the cycle of abuse and experiencing shame and pressure to not speak up about the abuse experiences. Therefore, clinicians would benefit from the support and endorsement of Arab community leaders, such as religious leaders, mayors, or well-known and respected professionals in the community, in order to assist in

challenging the mental health stigma and the shame associated with speaking up about DVA. The community leaders can also serve as educators with whom clinicians collaborate to lead psychoeducation groups offered for individual victims of violence, perpetrators, or victims' families. Although the involvement of religious leaders may serve as encouragement for many Arab women to pursue psychological support and services, it is crucial to deliberate on the percentage of Arab women who may not associate with a high level of religiosity or connection with the Arab community leaders. Therefore, the process of utilizing a community-based approach becomes similar to the common treatment planning theme of tailoring the interventions or approaches of therapy to the individual's wants, needs, and background.

The concept of mental health services is foreign to an overwhelming number of Arab Americans, and the acculturation levels of the Arab individuals may heavily weigh on clients' reluctance and concerns about confidentiality limits in mental health services, especially if the clinician comes from an Arab background or connects with Arab community individuals. This issue highlights the importance of addressing limits of confidentiality early in the intake process to ensure clients' comfort and engagement in subsequent stages of treatment.

Domestic Violence (DV) Supportive Resources

Domestic violence continues to be a sensitive subject and taboo topic for women from Arab backgrounds to speak out or seek help; therefore, it is crucial for clinicians to be well-informed about DV virtual or in-person supportive services and specialized organizations that deliver culturally responsive treatment and sensitive services tailored to the needs of battered women seeking shelter or support. Some of these available resources include:

Organizations & Websites

1. Los Angeles County's Domestic Violence 24-hour Support Services is a confidential hotline that can be reached at 1-800-978-3600 or www.LACITY.gov, offering immediate assistance, shelter, and other resources such as legal services through affiliations with various legal organizations.
2. The National Domestic Violence Hotline, which is accessible at 1-800-799-7233 or through their website at www.ndvhl.org, provides confidential support, safety planning, and resources to individuals experiencing domestic violence in over 200 languages.
3. National Coalition Against Domestic Violence (NCADV) offers referrals to shelters, policy work, counseling services and legal services for DV survivors, which are services accessible at 303-839-1852 or through their website, www.ncadv.org.
4. East Los Angeles Women's Center (ELWC) offers both a rape and battering hotline at 1-800-585-6231 and a wellness center providing sexual assault and domestic violence services for women as well as teen violence prevention workshops for young girls and women, which can be learned more about at their website, www.thewellnesscenterla.org.
5. Jenesse Center, Inc. is a hotline accessible at 1-800-479-7328 or through the website, www.jenesse.org, as a non-profit domestic violence intervention and prevention organization that also offers culturally responsive services to domestic violence survivors and families through offering education, resources, and referrals beyond temporary shelter.
6. Tahirih Justice Center is a nonprofit organization that offers culturally sensitive support through providing free legal and social services to immigrant women who are fleeing gender-based violence. The organization can be reached through their website, www.tahrih.org or their number, 1-866-575-0071.

7. Women's Shelters is a nationwide directory of emergency shelters and transitional housing for battered women escaping DV, and it can be accessed through their website, www.womensshelters.org.
8. Arab American Family Support Center (AAFSC) is a non-profit organization offering culturally sensitive and linguistically competent social services to immigrants and refugees through advocacy programs tailored to Arab and immigrant communities nationwide. The organization can be reached through their website, www.aafscny.org or their number, 1-718-643-8000.
9. National Network to End Domestic Violence (NNEDV) is a national advocacy group focusing on providing policy support, financial empowerment, and resources for DV survivors through their website, www.nnedv.org.

Peer Reviewed Articles

1. Bali, A. O., Omer, E., Abdulridha, K., & Ahmad, A. R. (2021). Psychological violence against Arab women in the context of social media: Web-Based Questionnaire study. *Journal of Medical Internet Research*, *23*(8), e27944. https://doi.org/10.2196/27944.
2. Kisa, S., Gungor, R., & Kisa, A. (2021). Domestic violence against women in north African and Middle Eastern Countries: A Scoping Review. *Trauma ,Violence & Abuse, 24(2),* https://doi.org/10.1177/15248380211036070.

Psychoeducational Videos

1. Domestic and family violence educational videos in Arabic produced by the Multicultural Center for Women's Health which can be accessed on their website www.MCWH.com.au .

APPENDIX B

Psychoeducational Manual Evaluation Questionnaire

Gendered Violence Targeting Arab Women

Thank you for your participation in this feedback questionnaire regarding your opinions and feedback on the presented domestic violence psychoeducational manual. Your insights are invaluable in shaping future edits of this manual and other resources addressing domestic violence. Please take a few moments to complete the following questions honestly and thoughtfully.

1. **Demographic Information:**

- Name (optional):
- Professional Title:
- Years of Experience in the mental health field:
- Years working with the Arab American population:

2. **Familiarity with the Manual:**

- Would you consider utilizing this domestic violence psychoeducational manual with the focus population of Arab women?
- Yes
- No
- Explain why:

3. **Content Evaluation:**

- How would you rate the clarity and organization of the manual's content?

- Excellent
- Good
- Fair
- Poor
- Which sections of the manual did you find most helpful in informing your work with the focus population of the manual?

- Which sections, if any, did you find lacking or in need of improvement?

4. **Relevance and Applicability:**

- How relevant do you think the topics covered in the manual would be when working with the Arab American population?
- Very relevant

- Somewhat relevant
- Neutral
- Not very relevant
- Not relevant at all

- Do you believe the strategies and interventions outlined in the manual would be applicable when working with Arab women experiencing domestic violence?
- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree

- What other relevant DV considerations and factors would mental health professionals benefit from learning about when working with the focus population of Arab women?

5. **Effectiveness:**

- In your experience, how effective would the techniques and interventions suggested in the manual be in assisting Arab women clients with domestic violence?
- Very effective
- Somewhat effective
- Neutral
- Not very effective
- Ineffective

6. **Usability and Accessibility:**

- How user-friendly did you find the manual in terms of relevance, language, and readability?
- Very user-friendly
- Somewhat user-friendly
- Neutral
- Not very user-friendly

- Not user-friendly at all

7. **Suggestions for Improvement:**

- What additional topics or information would you like to see included in future editions of the manual?

- Do you have any suggestions for enhancing the usability or effectiveness of the manual?

8. **Overall Satisfaction:**

- On a scale of 1 to 5 how satisfied are you with the domestic violence psychoeducational manual provided that you would recommend it
- 1 (very satisfied)
- 2 (somewhat satisfied)
- 3 (neutral)
- 4 (not very satisfied)
- 5 (not satisfied at all)

9. **Additional Comments:**

- Please feel free to share any additional thoughts, comments, or concerns about the manual or its implementation.

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